western health

Provider Manual

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westernhealth.com/providers

2024 WHA PROVIDER MANUAL | rev 5.2024

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Proprietary Information

The Western Health Advantage Provider Manual is proprietary. By accepting this manual, the medical group, physician or provider agrees not to disclose such information, to protect and hold the information confidential, and to use this manual solely for the purposes set forth herein.

1. Introduction

1.1. Guide to Using this Manual

Western Health Advantage (WHA) wants to engage its provider partners in a working relationship that is mutually beneficial. We have organized this Provider Manual to inform and provide resources to our contracted medical groups, network physicians and other providers of the Plan's guidelines and requirements. It addresses both administrative and health care services issues. At the end of the manual are frequently-used words and acronyms that are defined as they apply to WHA.

WHA updates the Provider Manual annually. In the event that new procedures and processes take effect after the manual has been published, WHA will provide updates through various means of distribution, including special mailings, the Clinical Provider Handbook, the quarterly Clinical Connections newsletter, by fax, and through the westernhealth.com website.

Questions regarding any of the information in this manual should be referred to WHA's Member Services Department between 8 a.m. and 6 p.m. Monday through Friday, at (916) 563-2250 or toll-free at (888) 563-2250.

Policies and Procedures Incorporated by Reference

Throughout this Provider Manual, we refer to policies and procedures that are available in the password- protected WHA Group Medical Administration section of the WHA website at westernhealth.com. The policies and procedures are incorporated into the Provider Manual by reference. If there is any conflict between a WHA policy and procedure and the text of this Provider Manual, the policy and procedure shall control. Copies of policies and procedures not available on the website may be obtained by contacting WHA's Member Services Department.

Modifications to this Manual

If at any time while this Provider Manual is in effect, a modification to the Provider Manual or any policy and procedure referred to in the Provider Manual is necessitated by a change in law, regulations, the National Committee on Quality Assurance (NCQA) or other applicable private sector accreditation standard, the Provider Manual and/or applicable policies and procedures shall be deemed to be automatically amended to conform to the requirements of such laws, regulations or standards. WHA will give providers written notice of such changes at least forty-five (45) business days in advance of the effective date thereof, unless the statute, regulation or standard requires a shorter timeframe for compliance.

If WHA proposes any material amendment to this Provider Manual or any policy and procedure other than those required by changes to law, regulation or accreditation standard, WHA will notify its providers at least forty-five (45) business days in advance unless otherwise unable. Such material amendment will automatically become effective unless the provider submits written notice of the provider's disagreement with the material amendment. If a provider does not agree with the material amendment, California law gives the provider the right to terminate the contract by giving the Plan notice of termination as set forth in the provider agreement.

1.1.1. Revised and New Information

- 1.4. Western Health Advantage Contacts has been updated
- 9.1. Provider Information has been updated
- 9.5.2. Individual Practitioner Termination has been updated
- 10.5.1. Access and Availability Standards and Monitoring has been updated

11.3.1. Advantage Referrals has been updated

1.2. Website

Providers have access to important information on a variety of topics, such as eligibility verification, benefit plan descriptions, the Advantage Referral Program, clinical and preventive health guidelines, forms, and Utilization Management policies/procedures, tools and templates through the password protected area of the WHA website at westernhealth.com. Since the website is a primary means of communicating with members, providers and the public, the website states the information that is collected on the website and how WHA uses the information collected by the website.

Providers must have a login ID and password to access the protected areas of the site. You may obtain a username and password by contacting WHA's Provider Relations Department.

1.3. Overview of WHA

Western Health Advantage is a locally owned and operated HMO incorporated in California in 1995 as a tax- exempt mutual benefit corporation. WHA's sponsors are Dignity and NorthBay Healthcare. Medical Groups in the WHA provider network include Mercy Medical Group, Hill Physicians Medical Group, Meritage Medical Network, NorthBay Healthcare, Providence Medical Network, and Woodland Clinic Medical Group. WHA is licensed in Sacramento, Yolo, Napa, Sonoma, Solano, Marin, and parts of Colusa, El Dorado, Humboldt, and Placer counties. The current product line includes a range of commercial and individual plans, including plans offered through Covered California, California's health benefit exchange. WHA is structured as a fully delegated model, in order to minimize duplicative administrative costs.

Effective January 1, 2023, WHA transitioned its behavioral/mental health services to Optum Behavioral Health (BH). This move to Optum is an effort to provide our members with an increased network of behavioral health providers (available through in-person and virtual visits) and a more robust network of behavioral health facilities. Covered members may self-refer to BH/MH services, but must first contact Optum to obtain Prior Authorization by calling (800) 765-6820. UC Davis active employees and retirees access BM/MH through Optum Health and can be reached at (888) 440-8225.

For members with chiropractic and acupuncture benefits, services are provided by Landmark Health plan of California, Inc., which is a Knox-Keene licensed chiropractic/acupuncture IPA. Western Health Advantage contracts with OptumRx, to provide outpatient pharmaceutical management services. Dental services are provided by Delta Dental, a Knox-Keene specialty plan licensed by the Department of Managed Healthcare (DHMC).

Pediatric vision services and eyewear are provided by EYEXAM Services, a Knox-Keene licensed vision plan.

1.4. Western Health Advantage Contacts

	Telephone:	(916) 563-3180
		(888) 227-5942

COMPLIANCE

Rebecca Downing, Esq., Chief of Legal Officer		(916) 563-3183
Jessica Warshaw, Corporate Compliance Director		(916) 563-2234
Christa Lee, Medicare Compliance Manager		(916) 614-6002
	Fax:	**(916) 563-3182**

FINANCE

Rita Ruecker, Chief Financial Officer		(916) 563-3188
Mary Ingram, Actuarial Services Director		(916) 563-2231
Stephanie Madsen, Finance Director		(916) 563-3193
	Fax:	**(916) 563-3182**

MEDICAL MANAGEMENT

Khuram Arif, MD, Chief Medical Officer, Chief Operating Officer		(916) 563-3186
Tasnim Khan, MD, Medical Director		(916) 614-6055
Kiran Biring, PharmD., RPh, MPH, BS, Pharmacy Director		(916) 563-2273
Blaire Richardson, RN, MS, MHA, CPHQ, Corporate Quality Director		(916) 563-2241
Judy Baillie, RN, Clinical Quality Manager		(916) 563-3196
Amanada Adams, Population Health Management Manager		(916) 437-3293
Kristen Tarrell, RN, Program Manager for Accreditation and Health Equity		(916) 532-7516
Alejandro Vasquez, Clinical Resources Intake Supervisor		(916) 563-2274
Dao Somera, Utilization Operations Director		(916) 563-2286
Elizabeth Gutierrez, Administrative Assistant		(916) 437-3242
Heather Erhard, Executive Administrative Assistant		(916) 614-6006
	Medical Management Fax:	**(916) 568-0278**
	Appeals and Grievances Fax:	**(916) 563-2207**

	Member/Provider Line:	**(916) 563-2250**
MEMBER SERVICES/ELIGIBILITY		**(888) 563-2550**

Rick Heron, Chief Experience Officer		(916) 614-6009
Vanessa Jackson, Customer Services Manager		(916) 563-2285
	Member Services Fax:	**(916) 568-0126**

PREMIUM ACCOUTING/ELIGIBILITY

Yaima Binford, Billing and Enrollment Director		(916) 563-2240
	Premium Accounting Fax:	**(916) 569-2042**
	Eligibility Fax:	**(916) 568-0334**

PROVIDER RELATIONS/CLAIMS PROCESSING

Syed Hamdani, Claims and Provider Relations Director (916) 563-2279
Loretta Teodecki, Claims and Provider Relations Manager (916) 614-6080
Fax: (916) 568-0331

Claims Billing Address:
Western Health Advantage
Claims Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Western Health Advantage Contacts **Telephone:** (916) 563-3180
(888) 227-5942

1.5. Medical Group Contacts

DIGNITY HEALTH/MERCY MEDICAL GROUP (916) 379-2700
3400 Data Drive
Rancho Cordova, CA 95670 **Fax: (916) 379-2768**

ADMINISTRATION
Rob Marchuk, VP Clinic Operations (916) 733-3482
Alan Shatzel, DO Chief Executive Officer (916) 733-3421

CLAIMS DEPARTMENT **Fax: (916) 733-3444**
Brent Keane, Director of Business Systems (916) 379-2963
Prince Chhina, Claims Manager (916) 851-2108
Claim Inquiry Line (916) 379-2888
(Out of group, out of area claims issues) **Fax: (916) 379-2870**

CONTRACTING DEPARTMENT
Shamima Ali, Contract Implementation Specialist (916) 851-2922
Kent Dazey, Manager (916) 851-2294
Stephen Zobel, Director, Managed Care (916) 851-2098

(Initial contact for scheduling audits, reviews, and office visits) **Fax: (916) 851-2601**

CREDENTIALING DEPARTMENT
Terri Woolf, Director, Credentialing (916) 379-2843

(Initial contact for all clinical quality of care grievances, QM audit, follow-ups, quarterly reports, credentialing issues) **Fax: (916) 733-3444**

MEMBER SERVICES DEPARTMENT
Lori Cook, Manager, Member Services (916) 379-2887
Fax: (916) 859-1533

MEMBER SERVICES (888) 858-8307
(916) 379-2888
Fax: (916) 379-2904

(Initial contact for patient billing, eligibility, HMO complaints/assistance that are <u>not specific to UM or QM: clinical quality of care / peer review issues)</u>

UTILIZATION MANAGEMENT/PROVIDER CARE COORDINATION
TBD, UM & Manager (916) 379-3923
Fax: (916) 379-2904

Jessica Villa	(916) 379-3041
	Fax: (916) 379-2904

QUALITY MANAGEMENT DEPARTMENT

Kimberly Cafarella, MD, Quality Improvement Chair Person	(916) 351-4800
	Fax: (916) 733-3459
Melanie Radko, VP Quality & Risk Management	(916) 389-8051
	Fax: (916) 589-1475

(Initial contact for all clinical quality of care grievances, QM audit, follow-ups, quarterly reports, credentialing issues)

CLAIMS BILLING ADDRESS:
Professional Claims ONLY
Dignity Health Medical Foundation
Attn: Claims Department
3400 Data D, 1st Floor
Rancho Cordova, CA 95670

Hospital Claims ONLY
Dignity Health Capitation and Special Contracts
3400 Data Dr, 3rd Floor
Rancho Cordova, CA 95670

DIGNITY HEALTH/WOODLAND CLINIC

632 W. Gibson Rd (530) 662-3961
Woodland, CA 95695

ADMINISTRATION

Scott Needle, MD, Medical Director	(530) 669-5357
Lisa Saucedo, Dir. Clinical Operations	(530) 669-5350
TBD, VP Clinic Operations	(916) 733-3482
	Fax: (530) 666-7948

CLAIMS DEPARTMENT

Brent Keane, Director of Business Systems	(916) 379-2963
Prince Chhina, Claims Manager	(916) 851-2108
Claims Inquiry Line	(916) 379-2888
(Out of group, out of area claims issues)	**Fax: (916) 379-2870**

CONTRACTING DEPARTMENT

Shamima Ali, Contract Implementation Specialist	(916) 851-2294
Kent Dazey, Manager	(916) 851-2294
Stephen Zobel, Director, Managed Care	(916) 851-2098

(Initial contact for scheduling audits, reviews, and office visits) **Fax: (916) 851-2601**

CREDENTIALING DEPARTMENT
Terri Woolf, Director, Credentialing (916) 379-2843

MEMBER/PROVIDER SERVICES DEPARTMENT
Lori Cook, Manager, Member Services (530) 668-2690
Fax: (530) 668-9833

QUALITY MANAGEMENT DEPARTMENT
Rajan Merchant, MD (530) 662-3961
Melanie Radko, VP Quality & Risk Management (916) 389-8051
Fax: (530) 589-1475

UTILIZATION MANAGEMENT/PROVIDER CARE COORDINATION
Christopher Swales, MD, Managed Care Medical Director (530) 668-2600
TBD, UM & CM Manager (916) 379-3923
Maria Ortiz, UM/CM Assistance (530) 662-3961 x4150
Fax: (530) 668-0193

CLAIMS BILLING ADDRESS:
Professional Claims ONLY
Dignity Health Medical Foundation
Attn: Claims Department
3400 Data Dr, 1st Floor
Rancho Cordova, CA 95670

Hospital Claims ONLY
Dignity Health Capitation and Special Contracts
3400 Data Dr, 3rd Floor
Rancho Cordova, CA 95670

HILL PHYSICIANS MEDICAL GROUP

SACRAMENTO (916) 286-7000
Fax: (916) 286-7019

DEPARTMENTS WITHIN HILL PHYSICIANS
Customer Service (800) 445-5747
Fax: (925) 552-6836

Health Resource Management (916) 286-7000
Fax: (925) 820-4311
(Urgent Authorizations)
option 3, then 1.

Hospital Admits/Discharges	(916) 286-7000 Option 3, then 2.

PRIMED EMPLOYEES ADMINISTRATION

Paula Friend, Regional Director, Sacramento	(209) 762-5002
Gladys Ramos, Regional Services Manager, Sacramento	(916) 286-7020

PRACTICE SUPPORT

Angelica Nixon - FQHC	(916) 296-7040
Kimi LaTurner - Auburn/Folsom Panels	(916) 643-7175
Veronica Guzman - North Panel	(916) 643-7175
Dan Aplaon - Central/South Panels	(916) 286-7023
Susan Sinton - Pediatric Panel	(916) 286-7046
Kang Vang - Specialty Panels	(916) 286-7026
Jennifer Herrera - Specialty Panels	(916) 286-7027
Eilene Andujo - Grass Valley	(916) 643-7166

PROVIDER NETWORK ASSOCIATE

Angelo Gonzales	(916) 286-7002

CARE MANAGEMENT AND CLINICAL CODE REVIEW (PREVIOUSLY MRU)

Mary Beth Anderson, RN, Manager, Health Resources Sacramento	(916) 268-7011
Katherine Posey, RN, Supervisor, Health Resources	(916) 286-7037

HEALTH RESOURCES MANAGEMENT

Danielle Portelli, RN, Supervisor, Health Resources	(925) 849-7962

AUTHORIZATIONS

Harnoor Chahal, Manager, Authorization	(916) 286-7089

MERITAGE MEDICAL NETWORK

Hangar No. 4
2100 S McDowell Blvd
Petaluma, CA 94954

Wojtek Novak, CEO	(415) 884-1840

NETWORK RELATIONS

Lucy Ramos, Network Liaison – Sonoma & Marin	(415) 884-1897
Dorothy Dukes, Network Liaison – Napa & Solano (also City of Santa Rosa)	(415) 475-6981
Nahea Aguiar, Director, Network Relations	(415) 483-8043

MEDICAL MANAGEMENT

J. David Andrew, MD, Medical Director - Marin	(415) 884-1840 x225
Julie Gersh, RN, Supervisor, Utilization Management	(415) 884-1840 x423
Juanita Collins, Sr. Manager, UM Audits & Compliance	(415) 884-1840

CLAIMS/MEMBER SERVICES

Leslie Harris, Director, Director of Claims and Call Center Operations	(415) 884-1840 x212
Customer Service – Central Valley	(833) 446-1758
Candice Carpenter, Claims Manager	(415) 884-1840 x279
Customer Service – Bay Area	(415) 884-1840
Jerica Renazco, Northern California & Central Valley	(415) 884-1840 x259

NORTHBAY HEALTH CARE

4500 Business Center Drive
Fairfield, CA 94534

PHYSICIAN GROUP ADMINISTRATION

Lori Muri, Assistant Vice President, Ambulatory Division	(707) 646-5706
	Fax: (TBD)

MANAGED CARE CONTRACTING – HOSPITAL & PHYSICIAN GROUP

Jaye Lynn Bonham, Director, Managed Care Services	(707) 646-3289
	Fax: (707) 646-3097

CREDENTIALING

Joy Cabusca, Acting Medical Staffing/Credentialing Supervisor	(707) 646-5609
	Fax: (707) 646-4817

QUALITY/PROCESS IMPROVEMENT DEPARTMENT

Ashley Chadbourne, Ambulatory Quality Supervisor	(707) 646-5778

GENERAL INQUIRIES (707) 646-3293

MEMBER SERVICES DEPARTMENT

General Number	(707) 646-3293
	Fax: (707) 646-3097

GRIEVANCES

Juanita Curiel-Johnson, Patient Experience Analyst	(707) 646-4282

OUTPATIENT CASE MANAGEMENT

Jessica Coyne-Lowe, Manager, Unitization Management	(707) 646-4241
	Fax: (707) 646-5114

ENROLLMENT

Vanessa Kronemeyer, Analyst, Health Plan Enrollment, Managed Care Services	(707) 646-3286
	Fax: (707) 646-4886

CLAIMS BILLING ADDRESS: 707-646-3337 (All Claims)

707-646-3283 Fax

PO Box 910
Fairfield, CA 94533

UC DAVIS HEALTH SYSTEM
2315 Stockton Blvd
Sacramento, CA 95817

ADMINISTRATION
Allen Hall, MD, Managed Care Medical Director — (916) 734-8203
Fax: (916) 734-7945

CLAIMS DEPARTMENT
Claims Inquiry — (916) 734-9900

(Capitated claims questions, billing questions and copay information.) — (800) 445-3936, option 1
Fax: (916) 734-9972

www.ucdmc.ucdavis.edu/managedcare

PATIENT RELATIONS
Patient complaints and grievances — (916) 734-9777
(800) 305-6540

Managed Care Operations — (916) 734-9900
(800) 445-3936

MEMBER SERVICES DEPARTMENT
Member Services Representative — (916) 734-9979
(800) 445-3936, option 2
Fax: (916) 734-9972

AUTHORIZATIONS — (916) 734-9900
(800) 445-3936, option 3
Fax: (916) 734-9971

PHYSICIAN REFERRAL CENTER
(For new patient referrals only) — (916) 734-9762
(800) 482-3284

PROVIDER & PAYOR RELATIONS
Sarah Thomas — (916) 734-2805
Fax: (916) 734-9661

UTILIZATION REVIEW

Utilization Review Line	(916) 734-9981
Patricia Hoffman, RN, UM Manager	(916) 736-5241
	(916) 816-5114/Pager
Daisy Planas, RN, Supervisor	(916) 734-9938
	(916) 816-8116
Donna Lightle, RN	(916) 734-9929/Pager
Cassandra Gassoumis, RN	(916) 734-9933
Debra Garduno, RN	(916) 734-9596
Michele Kerr, RN	(916) 734-9912
Mollie Nelson, RN	(916) 734-9916
Jennifer T Gaite	(916) 734-9925
Maria Claridad, RN	(916) 734-9908
Christian Reinheimer, RN	(916) 734-9624
Karen Johns-Smith, RN	(916) 734-9951
Thomas Woods, RN	(916) 734-7117
Veeda Mistler, RN	(916) 734-9186
	Fax: (916) 734-9974

MANAGED CARE SPECIALISTS

Roberta Espinoza	(916) 734-9955
Priscilla Guajardo	(916) 734-9964
Rebecca Holman	(916) 734-9957
Tonya Primus	(916) 734-9227
Sandra Munoz	(916) 734-9958
Debra Garcia, Administrative Assistant	(916) 734-9948
Vernessa Lauria, Administrative Assistant	(916) 734-9965
	Fax: (916) 734-9971

MANAGED CARE REPORT LINE

(For inpatient admissions, emergency services and acute transfer.)	(916) 734-9920
	(800) 445-3936

Claims Billing Address:
UCDMC Managed Care Operations
PO Box 179001
Sacramento, CA 95817

PROVIDENCE MEDICAL GROUP
200 W. Center Street Promenade
Anaheim, CA 92805

ADMINISTRATION

Jill Duplechan	Jill.Duplechan@stjoe.org

NETWORK RELATIONS

Eric Alegria, Chief Affiliated OPS/PHN	Eric.Alegria@stjoe.org

AUTHORIZATIONS

Alik Apikian, Director UM Referral Ops	Alik.Apikian@providence.org

CLAIMS CONTACTS

Gina Hays, Director of Claims	gina.hays@stjoe.org

CONTRACTING

Brad Blevins, GVP Contracting & Network Development	Bradley.Blevins@stjoe.org

CREDENTIALING

Sue Boyadjian, Manager Credentialing	Sue.Boyadjian@stjoe.org

MEMBER SERVICES

1-800-627-8106
Monday-Friday, 8-5pm

UTILIZATION MANAGEMENT

Tia Brooks, Regional Director UM Referral Ops	Tia.Brooks@providence.org

QUALITY MANAGEMENT

Susan Bell, Director Resolution Management	Susan.Bell@stjoe.org

CLAIMS ADDRESS

Providence Medical Foundation P.O. Box 70014 Anaheim, CA 92825-0027	(714) 937-6143 or nssclaimscustomerservice@stjoe.org

2. Benefit Plans

Copayment summaries for all of the WHA medical and prescription drug benefit packages and benefit riders are available through the WHA Medical Group Administration area on the "Providers" page of the WHA website at westernhealth.com. Questions about medical and prescription benefits should be directed to Member Services between 8 a.m. and 6 p.m. Monday through Friday, at (916) 563-2250 or toll-free at (888) 563-2250 and 711 for TDD/TTY.

3. Claims and Billing

3.1. Claims Processing

WHA complies with federal and state regulatory requirements and NCQA standards for the receipt, acknowledgement, payment and denial of claims. Generally, WHA has retained direct responsibility for claims handling for out-of-area emergencies.

In general, all other provider claims are the contractual responsibility of WHA's contracted medical groups, IPAs and hospitals and the in-area claims should be directed to the responsible party.

All providers shall submit claims timely, within 90 days of the DOS.

3.2. Requests for Medical Records

If WHA determines medical records are needed to pay a claim, the Plan will send a remittance advice noting that medical records are needed to adjudicate the claim. If records are not received timely, the claim will be denied.

3.3. Claim Denial and Payment

If a claim is denied, WHA will issue a denial letter to the provider and/or member, as appropriate. The member will be notified as to whether he/she is responsible to pay for the denied services. If a provider disputes the denial, the provider may file a dispute with WHA (see section 9.4 of in this Provider Manual). If a member disputes the denial, the member may submit a grievance to WHA as described in section 7.2 of this Provider Manual.

WHA acknowledges receipt of claims by ensuring that hard copy claims have been entered into the claims processing system within fifteen (15) days and electronic claims have been entered within two (2) days, permitting any provider to call WHA Member Services and inquire whether the claim has been received.

WHA issues claim checks five (5) times weekly (Monday – Friday) and pays claims in accordance with the turnaround times required by the State of California or Centers for Medicare and Medicaid Services ("CMS"), as applicable. Claims paid late will include any applicable interest and penalties calculated from the date the claim was clean.

A "clean claim" is one that may be processed without obtaining additional data from the provider of service or from a third party. It does not include claims under investigation for fraud and abuse or claims under review for medical necessity.

WHA pays amounts due under AB 1324 (Health & Safety Code section 1371.8) to the contracted medical group, IPA or hospital that paid a provider or, for directly-contracted providers, to the provider, in accordance with WHA's *"AB 1324 Payments and "Claims Payment Accuracy"* policies and procedures. All plan risk claims are subject to claim line and charge reviews, audit of billed charges

and/or other 3rd party claim pricing or claim reviews, to ensure completeness of claims and industry standards for claim coding and billing practices.

3.4. Misdirected Claims

Within ten (10) business days of receipt, for claims that are misdirected to WHA, the Plan shall forward, or deny, the claim as follows:

1. If the services involve emergency service/care and were considered in-area, WHA will forward the claim to our delegated Medical group, IPA, Hospital system or partner within ten (10) working days of receipt.
2. If the services do not involve emergency service or care:
    a. If the provider that filed the claim is contracted with the Plan's capitated Medical Group, IPA, Hospital system or partner, WHA will send the claimant/provider a notice of denial with instructions to bill the delegated Medical Group, IPA, Hospital system or partner within ten (10) working days of receipt.
    b. If the provider that filed the claim is not contracted with the Plan's capitated Medical Group, IPA, Hospital system or partner, WHA will forward the claim to our delegated Medical Group, IPA, Hospital system or partner and notify the provider their claim has been forwarded within ten (10) working days of receipt.

3.5. Third Party Liability

WHA's delegated entities are responsible to identify cases for which a third party may be liable for payment and to submit itemized charges to the third party along with a member's statement of third-party liability. The lien of a delegated entity is subject to a pro rata reduction for the member's attorney fees and costs in the underlying third-party case. WHA encourages its delegated entities to consider reducing a lien in those instances when the member's recovery is substantially disproportionate to the member's total economic damages or payment of the full amount of the lien would otherwise result in an undue hardship.

3.6. Coordination of Benefits (COB)

3.6.1. Coordination with another Group Health Plan (Order of Benefit Determination – Prime Carrier Rules).

These rules should be applied in the order in which they are listed in determining which plan is primary and which is secondary:

- *Rule 1* – Plan Without COB Provision is Primary Plan

If one contract contains a COB provision and the other does not, the insurer without the provision is the prime carrier.

The following rules apply when there are two (or more) plans and both contracts contain a COB provision:

- *Rule 2* – Plan Covering Patient as an Active or Retired Employee is the Primary Plan When the patient is the employee with one insurer and the dependent with another, the insurer that covers the patient as the employee is the primary plan.
- *Rule 3* – When the Patient is a Dependent Child with Both Insurers, the Birthday Rule

Applies

The plan of the subscriber whose birthday occurs earlier in the calendar year is the primary plan for the dependents covered under that subscriber's group health plan. The plan of the subscriber whose birthday occurs later in the calendar year is the secondary carrier for dependents covered under that subscriber's group health plan.

This rule also applies to the dependent children whose parents are living together but have never married. It does not apply to dependent children whose parents have been divorced or legally separated. (This revision has been recommended by the National Association of Insurance Commissioners (NAIC). Although the NAIC model is not law, it is used by many states as a basis for their COB policies. Please be aware, however, that all states may not follow this recommendation.)

- *Rule 4* – How Primary Plan for Divorced or Legally Separated Spouses is Determined

If spouses are legally separated or divorced and a court decree directs one parent to be financially responsible for the child's medical, dental, and/or other health care expenses, the plan of the parent who is financially responsible will be the primary plan.

If there is no court decree regarding health care responsibility, the insurer of the parent with custody is the primary plan.

- *Rule 5* – Unmarried Spouses with Legal Custody when there has been a divorce and the court has not assigned financial responsibility for the child's medical, dental, and/or other health care expenses, and the parent with legal custody of the child has not remarried, the plan of the parent with legal custody of the child is the primary plan for the child, and the plan of the parent who does not have legal custody is the secondary plan.
- *Rule 6* – Remarried Spouses

In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental, and/or other health care expenses, and the parent has remarried, the plan that covers the child as the dependent of the parent with custody is the primary plan, and the stepparent's plan is the secondary plan. The plan of the parent without custody is tertiary. If the parent with custody does not have his or her own health coverage, the stepparent's plan is then the primary plan and the insurer of the parent without custody becomes secondary.

- *Rule 7* – When the Court Orders Joint Custody

When the court has awarded joint custody of dependent children to divorced or legally separated parents, WHA applies the birthday rule.

- *Rule 8* – Retired and Laid-off Employees

When a retired or laid-off employee has more than one coverage, the plan that provides coverage to the member as an active employee is primary; the plan providing coverage as a retirement benefit is secondary. But see the rules regarding Medicare coverage below.

When rules one through eight do not establish an order of benefit determination the plan that has covered the patient the longest is the primary plan.

3.6.2. Medicare Secondary Payer

WHA would be considered the primary insurer for members meeting the following criteria:

- *Working Aged:*

A Medicare working aged individual is defined as a person who meets one of the following criteria:

- An age 65 or over working individual who:
    1. Works for an employer that employs twenty (20) or more employees, and is covered under that employer's health plan and entitled to Parts A & B;
    2. Age 65 or over and a spouse of a worker employed by an employer of twenty (20) or more employees who is covered under an employer's health plan and entitled to Parts A & B; or
- A self-employed worker or spouse age 65+ who is:
    1. Covered by the employer's health plan through association with a firm which employs twenty (20) or more employees, and
    2. Entitled to Parts A & B.

If Member is retired, over age 65, and part of an Employer Group Health Plan (EGHP), Medicare is primary regardless of group size. If Member is age 65 or over and covered by Medicare and COBRA, Medicare is always primary to the COBRA plan.

- *End Stage Renal Disease/Permanent Kidney Failure:*
    - A WHA commercial plan is primary to Medicare during a thirty (30)-month coordination period for beneficiaries who have Medicare coverage due to permanent kidney failure. This rule applies to both those with permanent kidney failure who have their own coverage under WHA and to those covered under WHA as dependents. Additionally, this rule applies without regard to the number of employees or to the enrollee's employment status. e.g., Member can be on COBRA. The period for which WHA would be the primary payer begins with the earlier of:

The first month of the enrollee's entitlement to Medicare Part A on the basis of permanent kidney failure, or

The first month in which the enrollee would have been entitled to Medicare Part A if he or she had filed an application for Medicare on the basis of permanent kidney failure.

- *Disability:*
    - A WHA commercial plan is the primary payer for claims for beneficiaries under the age of 65 who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. A LGHP is defined as an employer who normally employs at least 100 employees on a typical business day during the previous calendar year.
    - Note: This does not apply to disabled retirees. Medicare is always primary for retirees with a disability. Medicare is also primary to disabled members who are on COBRA.

3.6.3. Duplicate WHA Coverage

If a member is covered by more than one WHA commercial plan, WHA will apply Rules 1 through 8 of

Section 3.6.1 above. Members covered by more than one WHA plan who are not enrolled with the same PCP for both plans will not benefit from lower cost-sharing that would otherwise occur as a result of being enrolled in multiple plans.

In addition, when a benefit stipulates a maximum number of visits, the member is entitled to the number of visits in the plan with the greater benefit. For example, if one plan covers 20 visits and the other 50 visits, the member is limited to a total of 50 visits.

Lower cost-sharing:

- Deductible plan primary, Copay plan secondary: Secondary's copay applies until the secondary OOP MAX is satisfied, then covered in full.
- Copay plan primary, Deductible plan secondary: Secondary's deductible applies. Once secondary deductible satisfied, then covered in full.
- Copay plan primary, Copay plan secondary: Covered in full, copayments waived.

Deductible plan primary, Deductible plan secondary: Both deductibles apply. Once both deductibles are satisfied, then covered in full.

3.7. Pharmacy Benefits

With regards to pharmacy benefits, when the WHA plan is secondary, or a member has dual WHA coverage, the member must pay their applicable copayments and deductibles at the time of service and submit their receipts to WHA for reimbursement. A member will be reimbursed as long as the prescription is covered under their Pharmacy Benefit Plan and the member used a participating pharmacy. Maximum reimbursement to a member can never exceed what WHA would have paid if the WHA plan was primary. Dual WHA coverage requires the same PCP to be assigned to the member on both plans, and the limits and requirements as defined under section 3.6.1.

3.7.1. Disagreements with Other Insurers

Not all insurers operate under the jurisdiction of the Department of Managed Health Care (DMHC). In some instances insurers do not operate under any legal authority at all regarding COB. For this reason, WHA may encounter insurers, administrators, and others who would ordinarily be the primary carrier but refuse to pay. There is no practical recourse if they have different rules in their state or are a self-funded plan.

When disagreements arise with insurers, WHA abides by the rules employed by the other insurer. After dealing with the immediate matter of providing or paying for a covered service, WHA can still make an effort to recover payment from the other insurer.

3.7.2. Interaction with Other Insurers

When WHA is the Primary Carrier

- The WHA member is not entitled to an itemized statement reflecting the cash value of the services provided by the CMG and covered by the WHA plan (compliance with a request for itemization could enable a member to obtain unjust payment from an insurer or to document an itemized tax deduction far in excess of actual cost).
- The WHA member is entitled to a statement documenting copayments made to the CMG and charges for services not covered by the WHA plan.

- When WHA is the Secondary Carrier
- The CMG should obtain the signature of the member who is the policyholder with the other carrier on a standard Assignment of Benefits form.
- The CMG should also obtain from the member any claim form the other carrier might require.
- WHA's copayments are waived provided that both plans are copayment plans and payment as the secondary carrier does not exceed the amount that WHA would have paid as the primary carrier.

In the event that the payment would exceed WHA's liability as primary payor if the copayment is waived, the member may be billed for the WHA copayment. The member is also responsible for copayments if the primary plan is a deductible plan or if the WHA plan is a deductible plan and the deductible is not yet satisfied.

When the primary carrier is another HMO and the member is enrolled in two different CMGs (one with the primary carrier and one with WHA), the member may receive services at either CMG. In order for the WHA secondary coverage to cover the services provided by the primary CMG, the member must obtain authorization. However, the CMG should use its judgment regarding the situation prior to denying services for no authorization.

- Where the member has both Medicare Parts A & B and is enrolled in a Medicare Supplement plan through their EGHP, WHA and/or CMG will pay as secondary payer up to the allowable amount minus applicable copayments.

3.7.3. WHA's Right to Pay Others

A "payment made" by another health plan may include an amount that should have been paid by WHA. If this happens, WHA may pay the amount to the organization that made the payment. The amount is then treated as though it was paid under the member's WHA coverage. WHA does not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

3.7.4. Rights to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under WHA and other health plans. WHA and other health plans may share information for the purpose of applying these rules and determining benefits payable under multiple health plans covering the person claiming benefits. WHA need not obtain the consent of any person prior to doing this. Each person claiming benefits from WHA must give WHA any facts it needs to apply those rules and determine benefits payable.

3.7.5. Services Instead of Cash Payments

An "allowable expense" is a health care service or expense, including deductibles and copayments, covered at least in part by any of the health plans covering the person. When a health plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service is considered an allowable expense and a paid benefit. An expense or service that is not covered by any of the health plans is not an allowable expense. The reasonable cash value of any services provided to the covered individual by any service organization is deemed an expense incurred by the individual, and the liability of WHA is reduced accordingly.

3.7.6. Recovery of Excessive Payments by WHA

If the “amount of the payment made” by WHA is more than it should have paid under the COB provision, WHA may recover the excess from one or more of the persons it has paid or from any other person or organization that may be responsible for the benefits or services for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

3.8. Claim Processing

- WHA acts as a “clearing house” for claims processing. Delegated Entities funnel claims through WHA for purposes of tracking the deductible and/or OOP MAX for any given member/family.

WHA processes the claims as encounters through our claims processing system. WHA then reports back to the Delegated Entities with any deductible/copayment amounts, or accumulator totals.

- Deductibles/copayments are tracked on a calendar year basis (although Groups may renew at any time during the year during their open enrollment period).
- When members inquire at WHA about expected rates of payment for any given service, members will be encouraged to call their PCP, CMG and/or Contracted Hospital to obtain these amounts. While WHA can provide approximates, it does not know what procedure codes will be billed. In addition, there are a few IPAs that have different rates than transfer pricing.
- Claims that are received at WHA directly from the provider of service will be processed according to the Claims Processing Guidelines Policy and Procedures with regards to whether they are paid, denied, or misdirected. These claims would not be processed as encounters; rather they would be processed for payment, denial, or misdirected claim.
- All claims received from Delegated Entities will be considered as authorized and will be processed for “encounter” payment at the current transfer pricing or provided rates. If the provider of service is not a WHA provider, the Delegated Entities must provide the contracted allowed amount. Claims that are not authorized or claims to be denied for any reason should remain at the Delegated Entities and be handled by their claims department.
- The claims will be processed in order of receipt by WHA (not the CMG date stamp). This will ensure accurate tracking of when the deductible or OOP Max was met for any given member/family. Note: WHA will receive a daily file from its pharmaceutical vendor with the dollar amounts spent on pharmacy items. This file is loaded into WHA’s claims operating system and is added to the Medical claims deductible. It is possible that the deductible may be exceeded at any given time. See section 3.6.2, “Out of Pocket Refunds” for the refund process when applicable.
- An “explanation code” is added to each encounter claim processed to identify the CMG or Contracted Hospital once the claim is processed.
- To ensure timely processing of the claims, a claims batch will be run nightly (Monday – Saturday). The turnaround time for non-837 encounter claims received, starting with the receipt date of the claims at WHA to completion of the process shall be no longer than fourteen (14) calendar days. This will be monitored for compliance. Clean 837 encounter claims are processed within two (2) working days. 837 claims with exceptions (member,

provider, or coding errors,) which require review process shall be processed no longer than fourteen (14) calendar days.

- Deductible and Out-of-pocket amounts are tracked in WHA's Claim Operating system. These amounts will be updated nightly to WHA's website and accumulator files. They can be viewed at westernhealth.com and will be accessible to the Delegated Entities with an appropriate login and password. Members may also be able to access their own deductible amounts by using their online MyWHA account or contacting Member Services.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-563-2250, TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

3.8.1. In the Event Members Do Not Pay Their Deductibles/Copayments

- Under AB 2470, WHA is limited in its ability to terminate a member from the Plan. Non-payment of copayments or deductibles has been specifically rejected by the Department of Managed Health Care (DMHC) as a basis for termination of a member without a grace period. CMGs/ IPAs may work with members to put them on payment plans or take other similar administrative steps to attempt collection.

3.8.2. Out of Pocket Refunds

- WHA works to identify Plan members who have met or exceeded their Out of Pocket Maximum.
- If an excess amount is identified via reporting or information provided by the member, reconciliation is completed.
- WHA's process date of the claim is used to identify which claim satisfied the Out-of-Pocket Maximum, as well as to identify any claims that will need to be reprocessed.
- WHA will refund the member directly for any excess payments by the member for WHA risk claims or prescription claims.
- If an encounter claim requires correction, the applicable Medical Group/Hospital for any Medical Group/Hospital risk claims that require an adjustment will be notified for a member refund or provider payment.

3.9. Surcharges

In no event, including but not limited to non-payment by WHA, or WHA's insolvency or breach of this

Agreement, shall any provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against, members or persons other than WHA acting on a Member's behalf for Covered Services. In the event WHA receives notice of any such Surcharges being applied by a provider to Members, WHA shall notify the provider of its violation of this section and the provider shall immediately cease billing the Member or, if a provider has collected funds from a Member for Covered Services, a provider shall forthwith refund the same to the Member.

This provision does not prohibit collection of copayments or deductibles or billing and collection for non-Covered Services rendered to Members.

In addition, a provider shall report to WHA in writing all surcharge and copayment moneys paid by Members directly to the provider.

3.10. Encounter Data

CMGs are required to provide WHA with the information described below, via electronic transmission in the format required by federal HIPAA regulations 45 CFR § 162.923 and any successor requirements relating to standard transactions, for each encounter with a Member. Electronic encounter information must be complete, accurate and shall include full claim details and adjudication details including, but not limited to, allowed, copay, coinsurance, deductible and paid amounts. Encounter data shall be provided to WHA daily, excluding Saturday, Sunday, and any holidays, or as frequent as mutually agreed upon. Encounter reporting shall be in accordance with, but not limited to, the current version of the Healthcare Effectiveness Data, Information Set (HEDIS) or as defined in procedures/guides developed by WHA. WHA will provide reports to the CMG in an electronic format, detailing its acceptance or rejection of the CMG's monthly encounter data submissions, including an error and omissions report. The CMG shall promptly provide WHA with all corrections to and revisions of such encounter data transmissions identified on the monthly reports, to cure any deficiencies that WHA determines exist in the quality or quantity of the encounter data reported.

4. Credentialing & Recredentialing

WHA delegates credentialing and recredentialing functions to its CMGs/IPAs. Delegates are expected to meet all regulatory and contractual requirements, as well as NCQA credentialing standards to maintain their delegated status.

Both WHA and its delegated groups maintain a formal Credentialing Committee that meets regularly to review practitioners' initial credentialing and subsequent recredentialing applications and files. All practitioners must be recredentialed every 36 months per NCQA standards. The initial credentialing of a new practitioner must be completed and formally approved by these committees before the practitioner can render health care services to a WHA member. Practitioners have the right to review the information that was submitted to support their credentialing application, correct any information errors, and be informed of the status of their credentialing/recredentialing application upon request.

If any recredentialing documents or findings are questionable, appropriate investigation and follow up must occur before the practitioner is allowed to continue providing services to WHA members. In the event that a practitioner fails to meet the quality standards of the CMG/IPA and/or WHA, the organization will take appropriate action and will inform the practitioner of their appeal rights. Practitioner suspension and/or termination shall be reported to the appropriate authorities.

Between recredentialing cycles WHA and the delegates carry out planned ongoing monitoring activities that include the collection and review of Medicare, Medicaid and licensure sanctions and the review of practitioner specific complaints and adverse events including practitioner office site quality issues. WHA sets standards and thresholds for office site criteria and medical record keeping practices that are applicable to all network

practice sites and are included in oversight of the delegate's performance.

Semi-annually WHA provides the CMGs/IPAs with Practitioner History Reports detailing grievances received by the Plan. These reports contain the history of complaints and grievances in access, attitude/service, quality of care and practitioner office site quality received for each practitioner specifically relating to the practice of medical care. Information from these reports can be included in the practitioner's credentialing file and referred to at the time of recredentialing.

All delegates are subject to oversight activities including an annual virtual or onsite visit that includes an audit of their credentialing files, review of their credentialing committee minutes, and an assessment of the ongoing monitoring activities they conduct between recredentialing cycles. Annually delegates submit their current credentialing policies and procedures to the Plan and at least semi-annually they report their credentialing activities.

For detailed information about the credentialing/recredentialing processes, the appeal process, or the Practitioner Office Site Quality Standards, see WHA's Credentialing policies and procedures in the provider section of WHA's website or contact WHA's Member Services Department and ask to speak with WHA's Quality and Accreditation Manager.

5. Population Health Management Programs & Services

The following programs and services offer two-way interaction. Once enrolled, members receive self-management support, health education, or coordination of care services. Interactive communication may include telephonic, live chat, secure email, and/or online contacts. Members may choose to opt-out of these programs or services at any time by contacting Member Services.

- Chronic Care/Condition Management
- Virta Health for Diabetes Nutrition Support
- Livongo Hypertension Management Program
- Maven Maternity Program
- Real Appeal Weight Loss
- Real Appeal Diabetes Prevention
- Nutritional Counseling
- Quit for Life: Tobacco Cessation
- Fonemed (Nurse Advice Line)
- Behavioral Health
- MYWHA - Wellness

5.1. Chronic Care/Condition Management Programs

WHA's Chronic Care/Condition Management programs are offered through Optum®, an NCQA accredited organization, and are covered benefits with no additional cost to members:

Program Identification Criteria: Members may qualify to participate in one of the programs listed below based on Optum's criteria that are similar to HEDIS standards.

DM Program Services	Asthma - Pediatric
Age	5-17 years old
Identification Period	24-month claims data look-back period.
Identification Criteria	Inclusion: • Age; and • One or more asthma-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct asthmatic pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Members less than 6 years of age; or • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has childhood dementia; or • Permanent resident in custodial nursing home setting.

DM Program Services	Asthma - Adult
Age	18 years or older
Identification Period	24-month claims data look-back period.
Identification Criteria	Inclusion: • One or more asthma-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct asthmatic pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Members less than 18 years of age; or • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has severe dementia; or • Resident in custodial nursing home setting.

DM Program Services	Chronic Obstructive Pulmonary Disease (COPD)
Age	40 or older
Identification Period	24-month claims data look-back period.

Identification Criteria	Inclusion: • One or more COPD-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct COPD pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has severe dementia; or • Permanent resident in custodial nursing home setting.

DM Program Services	Coronary Artery Disease (CAD)
Age	35 years or older
Identification Period	24-month claims data look-back period.
Identification Criteria	Inclusion: • One or more CAD-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct CAD pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has severe dementia; or • Permanent resident in custodial nursing home setting.

DM Program Services	Diabetes - Pediatrics
Age	6-17 years old
Identification Period	24-month claims data look-back period.

Identification Criteria	Inclusion: • One or more diabetes-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct diabetic pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Members less than 6 or 18 years of age or older; or • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has childhood dementia; or • Member with diabetes insipidus; or • Member with gestational diabetes; or • Resident in custodial nursing home setting.

DM Program Services	Diabetes - Adult
Age	18 years and older
Identification Period	24-month claims data look-back period.
Identification Criteria	Inclusion: • One or more Diabetes-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct diabetic pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has severe dementia; or • Has childhood dementia • Member with diabetes insipidus; or • Member with gestational diabetes; or • Resident in custodial nursing home setting.

DM Program Services	Heart Failure (HF)
Age	18 years or older

Identification Period	24-month claims data look-back period.
Identification Criteria	Inclusion: • One or more heart-failure-related claim(s) as identified with the Episode Treatment Group (ETG) codes within 24 months of the identification period; or • One or more distinct health-failure pharmacy claim(s) identified by the Episode Treatment Group (ETG) codes within 24 months. Exclusions: • Members less than 18 years of age; or • Member is eligible for and has received or is receiving hospice services in the last 6 months; or • Hospitalized for transplant through 1 year post transplant; or • ESRD or undergoing dialysis anytime during the identification period; or • AIDs/HIV during the identification period; or • Has severe dementia; or • Permanent resident in custodial nursing home setting.

The program goal is to assist members in the management of their chronic condition. It also serves to assist network clinical providers in managing the patient's care by providing evidenced-based information and treatment recommendations. Participation in WHA's programs is voluntary, and members can opt-out at any time by contacting WHA or Optum.

Member Identification: Potential participants are identified through one or more of the following resources:

- Claims
- Member self-referrals
- Physician referrals
- Contacting Optum or WHA directly
- Completing a *Chronic Care/Condition Management* Referral Form located at mywha.or/DMRF. The form can be mailed or faxed to WHA.

Optum uses evidence-based interventions that follow the recommendations of nationally recognized sources. Health improvement experts including nurses, specialists and coaches help DM program participants define and reach their personal health goals. Interventions are based on the severity of the participant's condition and may include:

- Digital remote patient monitoring services via mobile app or Optum provided tablet. Based on the Enrolled Member's condition, the Enrolled Member may also receive other RPM Devices and/or
- Telephone contact and coaching by a health care professional regarding nutrition, medication management, physical activity and community resources.

For more information about the programs, contact WHA Member Services or contact Optum directly at (877) 793-3655, Monday through Friday, 8 a.m. - 6 p.m. PST.

5.2. Virta Health for Diabetes Nutrition Support

Virta Health is an innovative, nutritional treatment program that reverses type 2 diabetes, without the risks, costs, or side effects of medications or surgery. Virta's telehealth program helps people lower their blood sugar and hemoglobin A1c, making it possible to reduce diabetes medications and lose weight. Tools and resources for members include:

- A physician-led care team: 24-hour access to Virta's board-certified clinical providers and healthcare professionals who coordinate care as needed with the member's primary care provider
- One-on-one health coach: members can message their Virta Health Coach, available on-demand to help answer questions on nutrition while offering encouragement
- Diabetes testing supplies: Virta provides members with a bodyweight scale, a meter with glucose and ketone strips, lancets, and swabs and if needed, a blood pressure cuff
- Digital educational tools: Members can access videos and recipes, and engage with a private online support community through Virta's website and mobile app

This program is offered at no additional cost to qualifying members. Refer patients to mywha.org/Virta to find patient application and more information.

5.3. Livongo for Hypertension

(Teladoc): For qualifying members over the age of 18 living with hypertension. This comprehensive hypertension management program includes a suite of tools including a connected blood pressure monitor, real-time insights after each reading, health education, and one-on-one support from expert coaches. Members also have access to Livongo's wireless, mobile, and web-based hypertension management systems and technologies through a personalized web portal.

5.4. Maven Maternity

Maven Maternity offered through Optum is an innovative digital platform available to all eligible members who meet the following criteria: pregnant/partner of a pregnant person; postpartum up until 3 months after delivery; experienced a pregnancy loss within the last 12 months. Services in the Maven program include: 1) community resources, 2) personalized education materials, 3) advocacy and navigation support, 4) video appointments and messaging with a large network of virtual coaches and 5) "Partner Track," which enables partners to create their own accounts and access content specific to the partner experience.

<u>Kaia Digital Physical Therapy:</u>

Members with acute or chronic neck, shoulder, back, hip, wrist, or knee pain can benefit from timely personalized physical therapy that is accessible anytime or anywhere. Optum brings this Kaia program to WHA members **via a smartphone app**.

- **On-demand pain relief care** in the convenience of an app
- **Workouts tailored to you** with some as short as 15 minutes
- **Bite-sized lessons** to help you recognize where pain is coming from
- **1-on-1 health coaching** with certified professionals
- **No added cost —** as part of a WHA health plan (check to ensure eligibility)

- **Strengthening exercises** plus relaxation techniques for pain management

  startkaia.com/westernhealth.

Nutritional Counseling: For members who meet specified medical criteria and demonstrate a documented readiness to make nutrition and lifestyle changes. This benefit supports members in weight management, whether for addressing obesity, eating disorders, or needed weight gain. Prior authorization is required to receive these covered services. For more information, go to mywha.org/nutrition.

5.5. Real Appeal: Weight Loss

Real Appeal Weight Loss includes a customized weight loss plan, personalized coaching with online group sessions, a digital library of health-related content, and an online dashboard to track their progress for eligible members.

5.6. Real Appeal: Diabetes Prevention

Real Appeal Diabetes Prevention from is for eligible members who are at risk for type 2 diabetes. This no-cost program is designed to help participants take small, doable steps that lead to big results. Participants receive personalized coaching, tracking tools, weekly online group classes and a kickoff success kit that includes a scale, pedometer, exercise DVDs and more.

5.7. Nutritional Counseling

Nutritional counseling is available to qualifying members to support weight management issues. Whether dealing with issues of obesity, eating disorders, or needed weight gain, talk to your doctor to see if you meet specified medical criteria, so you can get a referral to a nutritionist for visits. You'll have the same cost-sharing that you would have for a primary care office visit.

5.8. Quit for Life: Tobacco Cessation

Quit for Life helps members with tobacco cessation and is designed to give members the confidence to quit for good, with the support of Nicotine Replacement Therapy (NRT), access to coaches and tools to develop a path to enjoying life without tobacco. Quit for Life gives you a personalized Quit Plan, 1:1 access to coaches via phone, chat, or text, as well as group video sessions, all at no added cost. www.wha.org/quit

5.9. Routine Case Management (CM) & Complex Case Management (CCM)

WHA delegates routine and complex case management functions to its contracted medical groups/IPAs. Members who qualify for CM/CCM services include those with complicated care and treatment needs, either for a chronic medical and/or BH condition or for complex acute conditions requiring coordination of multiple services and specialized healthcare resources. Medical group/IPA staff must adhere to all NCQA PHM-5 current accreditation standards for complex cases.

Per NCQA accreditation standards, WHA and its delegated groups use the following sources to identify members for case management:

Data Sources

- Hospital discharge data;
- Pharmacy data, if applicable;

- Data collected through UM management process if applicable;
- Claim or encounter data;
- Data supplied by purchasers, if applicable;
- Data supplied by members or caregivers; and
- Data supplied by practitioners;

Referral Sources

- Practitioner;
- Member or caregiver;
- Discharge planner;
- Disease Management program; and
- Health Information Line, if applicable

Routine case management assistance is usually provided to qualifying members with short-term, health care or care coordination needs. Complex case management assistance is provided to members of any age with more complicated acute and/or chronic conditions requiring multiple coordinated services from numerous specialists and ancillary service providers. The types of health conditions, situations and/or populations that must be assessed/screened for complex case management eligibility include, but are not limited to the following:

- Catastrophic illness or injury
- End-state respiratory failure
- Patients with multiple diagnoses, rare high-risk chronic diseases
- Children and Adolescents
- Patients with developmental, physical and other disabilities that require multiple services
- Chronic illnesses that result in high utilization
- Serious and persistent Mental Illness

Case management services can be requested by a member/representative by contacting the medical group/IPA's UM or CM department or by contacting WHA's Clinical Resource nurse by calling WHA Member Services at (916) 563-2250 or (888) 563-2250 or TTY/TDD 711 and asking to speak with a Clinical Resources representative, who will forward the request to the member's group. Complex case management services delegated to WHA's contracted medical groups/IPAs are monitored by the Plan for appropriateness and effectiveness. Delegation oversight activities may include, but are not limited to, the following: annual delegation audits; review of CCM tracking systems; online or hardcopy file review; and review of required semi-annual reports and statistics. Additionally, WHA at the Plan level conducts semi-annually CCM program member experience (satisfaction) surveys to obtain member feedback regarding their experiences with their group case managers and the program services provided to them.

For further information regarding WHA's Case Management Programs see WHA's UM policy titles: "*Case Management - Routine"* and "*Case Management"* on WHA's website.

5.10. Nurse Advice Line: Fonemed

WHA's provides a nurse advice line through FoneMed's services. Fonemed provides triage and screening services 24/7 by California Registered Nurses to guide members to the most appropriate level of care.

Fonemed also educate members who have health-related questions such as:

- How to care for minor injuries and illnesses;
- The most appropriate type of care to seek based on their medical concern;
- How to identify and address emergency medical concerns;
- How to prepare for doctor visits;
- Understanding their prescription medications;
- Lifestyle choices to improve their health; and
- Lab tests.

WHA members can access the Fonemed services by calling this toll-free number: (888) 656-3574. Hearing-impaired participants dial in by calling 711.

Visit mywha.org/healthsupport for more information.

5.11. Behavioral Health Depression Prevention Programs

WHA collaborates with Optum in developing depression prevention programs. The following programs include telephonic outreach and/or health education mailers.

5.11.1 Depression Screening through Utilization Management (UM), Case Management (CM) & Chronic Care/Condition Management Programs

The targeted populations for this program are WHA members aged 18 through 49 with a chronic medical condition (e.g., diabetes, asthma, cardiac issues, chronic pain, cancer, etc.) who have been identified as potential candidates for depression intervention.

The goal of this program is the early identification, referral, and treatment of a depression disorder and patient/family education about depression for patients identified with a co-occurring chronic or acute medical condition.

Sources used to identify potential program candidates include:

- Optum: Screens members for depression using the PHQ tool; participants screening positive for depression are referred for BH services.
- Utilization Management: Through hospital admission notifications and prior authorization processes: Specific diagnosis and conditions are screened by WHA for potential candidates at-risk for depression.
-

For more information about these programs, you may contact Member Services or visit mywha.org/BH.

5.12. WHA Health & Wellness Programs and Services

WHA's health and wellness services and resources create awareness about choices that encourage a healthy lifestyle.

5.12.1 Preventive Health Guidelines

WHA's develops its preventive health guidelines (PHGs/guidelines) based on the recommendations established by the United States Preventive Task Force (USPSTF), the Centers for Disease Control and Prevention (CDC), the Advisory Committee for Immunization Practices (ACIP), and other nationally recognized sources.

WHA's current guidelines address:

- Children: Birth to 17 years
- Young Adults to Older Adults: 18-65+ years
- Prenatal Prevention Guidelines
- Immunizations

WHA presents the guidelines to the Quality Improvement Committee (QIC) at least every two (2) years and when updated. When the guidelines are updated or revised, clinical providers receive notification via the quarterly newsletter. The guidelines are available to view or download at mywha.org/phgs. Copies are available upon request by contacting Member Services or Provider Relations.

WHA encourages practitioners to use the guidelines and recommendations in managing their patients' care, and as a means to promote patient education regarding life-saving preventative services and screenings.

WHA encourages practitioners to use the guidelines and recommendations in managing their patients' care and as means to promote patient education regarding life-saving prevention services and screenings.

5.12.2 Focused Health Campaigns

WHA collaborates with the leaders of its medical groups to develop quality improvement campaigns. The campaigns vary, and focus on educating members and/or clinical providers on certain preventive services.

5.12.3 Health Reminders

WHA provides postcard reminders and e-newsletters to members about missed preventive services. Current campaigns include the following:

- Asthma
- Breast Cancer Screening (BCS)
- Chlamydia
- Colorectal Cancer Screening
- Cervical Cancer Screening (CCS)
- Dilated Retinal Eye Exams (DRE) for those living with diabetes
- Prenatal Care
- Postpartum care

- Well child visits and immunizations
- Adolescent well care and immunizations

5.12.4 Incentive Programs

WHA created incentive programs designed to encourage members to complete specific screening examinations.

Once verification of the exam is completed, some members receive a gift card, while others have their names entered into a drawing. Members can learn more by contacting WHA Member Services or visiting mywha.org.

WHA now contracts with a vendor, Icario, who can assist WHA in closing gaps in care for our Exchange and CalPERS members. These measures or activities are currently part of WHA's outreach campaign: 1) Annual Wellness Visit; 2) Breast Cancer Screening; 3) Colon Cancer Screening; 4) Controlling Blood Pressure; 5) Diabetes Program Participation; 6) Immunization visits from birth to 12 months, 13 to 24 months, and 11 to 13 years; 7) Pap tests; 8) Prenatal Care visit, and 9) Postpartum care visit. Eligible members completing a preventive service can receive a gift card.

5.12.5 Web-Based Wellness Program

WHA's web-based wellness program is available through American Specialty Health Healthyroads program, an NCQA accredited Wellness & Health Promotion (WHP) organization. Members can complete a Personal Health Assessment (PHA) that provides the following:

- Assessment of member's current health status followed by a personalized health plan based on results
- 24/7 access to online trackers, video courses, access to personalized action plans based on PHA results, a robust health library with downloadable/printer-friendly health articles.

For more information, contact WHA's Member Services.

5.12.6 Health Education Classes/Support Groups

WHA collaborates with its contracted medical groups to promote a variety of health education and wellness classes. Members can take advantage of most of these courses and support groups regardless of their PCPs' assigned medical group.

5.12.7 Member Magazine

WHA's quarterly member magazine, "Advantage", is mailed to each subscriber and includes articles addressing health and wellness, community events, and benefit updates. The magazine directs members to WHA's website at mywha.org/Advantage for additional information on a variety of health related topics, benefit information and resources.

5.12.8 Health Club Membership

WHA partners with numerous local health clubs to offer special rates to WHA members. Members can

learn more at mywha.org/gyms.

WHA offers fitness and wellness discounts to members through the ChooseHealthy program. It saves money on popular products, therapeutic massage services, and fitness center memberships. Additionally, members can take part in evidence based health classes and access a variety of educational articles at no extra cost. Go to mywha.org/discounts for more information.

5.13 Clinical Health Resources

5.13.1 Clinical Practice Guidelines

WHA adopts Optum's guidelines for the chronic care/condition management programs provided to WHA members. The guidelines are adopted by Optum from nationally recognized clinical practice guidelines (guidelines) that address non-preventive acute and chronic medical conditions. WHA also adopts preventive and non-preventive behavioral health conditions developed and/or adopted by Optum Behavioral Health. The guidelines are: 1) relevant to WHA's membership, 2) are evidence-based, and 3) are developed using expert opinion.

The guidelines are reviewed and updated at least every two (2) years. The guidelines are available online at mywha.com/cpgs. When the guidelines are updated or revised, clinical provider receive a notification published in the clinical provider newsletter. Copies of the guidelines are available by contacting Member Services.

1) Behavioral Health

Condition	Guideline	Source
ADHD	2019 Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents	AAP, AACAP, AAFP
Alcohol/Opioid/Substance Use Disorders	2018 Pharmacological Treatment of Alcohol Use Disorder 2020 Treatment of Opioid Use Disorder 2021 Management of Substance Use Disorders	APA ASAM VA/DoD
Anxiety	2020 Assessment and Treatment of Children and Adolescents with Anxiety Disorders	AACAP
Autism	2020 Identification, Evaluation, and Management of Children with Autism Spectrum Disorder	AACAP, AAP

Dementia	2016 Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia	APA
Depression	2019 Treatment of Depression Across Three Age Cohorts	APA
Eating Disorders	2022 Treatment of Patients with Eating Disorders_ DRAFT 2021 Identification and Management of Eating Disorders in Children and Adolescents	APA AAP
PTSD	2017 Treatment of PTSD 2017 Management of Post-Traumatic Stress and Acute Stress Reaction	APA VA/DoD
Schizophrenia & Psychosis	2021 Treatment of Patients with Schizophrenia 2019 Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents	APA SAMHSA
Suicidal Patient	2019 Assessment and Management of Patients at Risk for Suicide 2020 Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth Ages 10-24 2021 Prevention and Treatment of Anxiety, Depression, and Suicidal Thoughts and Behaviors Among College Students	VA/DoD SAMHSA SAMHSA
Transgender Health	2022 Standards of Care for the Health of Transgender and Gender Diverse People, Version 8	WPATH

The Behavioral Health Clinical Practice Guidelines have been expanded and updated to include additional behavioral health diagnosis commonly seen in primary care.

Also, a new national Suicide and Crisis Lifeline, funded by SAMHSA and operated through the existing National Suicide Prevention Lifeline, went live in July 2022. People can now call or text “988” or chat at 988lifeline.org for themselves or if they are worried about a loved one who may need crisis support.

This lifeline is available for members who are experiencing any type of mental health-related distress or suicidal crisis. The lifeline is available 24/7 in English and Spanish.

2) Medical

Condition	Guideline	Source
Asthma	2023 Global Strategy for Asthma Management and Prevention	GINA
Blood Pressure/Hypertension	2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults	ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA
Congestive Heart Failure	2022 Guideline for the Management of Heart Failure	ACC/AHA/HFSA
Chronic Obstructive Pulmonary Disease	Global Strategy for Prevention, Diagnosis and Management of COPD: 2023 Report	Global Initiative for Chronic Lung Disease
Cardiovascular Disease/CAD	2019 Guidelines on the Primary Prevention of Cardiovascular Disease 2020 Recommendations for Primary Prevention of CAD in Women	ACC/AHA
Diabetes	– Standards of Medical Care in Diabetes - 2023	American Diabetes Association

These guidelines are not a statement of benefits. Individual coverage will vary and needs to be verified by the Plan including the terms, limitations, and exclusions.

Your feedback matters. Comments or concerns about the information? Contact Khuram Arif, M.D., CMO at k.arif@westernhealth.com or at 916-563-3186.

5.13.2 Provider Newsletter

WHA's provider newsletter, "Clinical Connections", is published quarterly and emailed to all network practitioners. The newsletter addresses issues of interest to the practicing physician, regulatory changes/articles, updates on various WHA programs, pharmacy benefit/management information, and QI collaborates with the medical groups. The results of QI activities and notification of information that is available on the WHA website. Electronic versions of the member and provider communications can be found at https://www.westernhealth.com/provider/secure/provider-communications/.

5.13.3 Social Determinants of Health/Health Equity

Beginning in 2023, WHA has contracted with Optum to identify members who may have food, housing and/or transportation needs. Lists of these members with potential social determinants of health (SDOH) will be sent to their respective medical groups for case management screening and interventions. Use of SDOH data positions WHA and providers to anticipate members' needs, discover ways to minimize the health impacts of non-clinical factors, and work towards closing gaps in care. Be on the lookout for ways in which you can participate and updates regarding our health equity journey in WHA's publications and the Clinical Connections e-newsletters. For additional information, comments or ideas reach out to healthequity@westernhealth.com.

6. Member Enrollment and Assignment

6.1. Member Enrollment

It is WHA's policy that new group enrollments, member enrollments, enrollment changes and terminations are processed in a timely manner. All new Members enrolling in WHA are processed within five (5) business days. Applications received by WHA to add or delete a dependent, change a name/address, or change a PCP are also processed within five (5) business days. All new members will be issued a Member Identification card that includes their Member ID number.

6.1.1. Newborns

Newborns are considered to be covered under the Mother for the first thirty (30) days. The newborn must obtain services from providers within the mother's assigned medical group during this thirty (30) day period. To avoid any gaps in care, WHA must receive an enrollment request to add the newborn within the Special Enrollment Period (SEP). The effective date of the newborn is retroactive back to the first of the month following date of birth when received under a SEP.

The newborn's medical group can be changed effective the first of the month following the initial 30 days of coverage. If the newborn remains hospitalized longer than 30 days following the date of birth, the child must continue to obtain services from providers within the mother's assigned medical group until the first of the month following discharge from the hospital. For more information, refer to the "*Newborn Enrollment"* policy on the WHA website at westernhealth.com.

The effective date for newborns for certain employer groups can be the date of birth. The newborn must obtain services from providers within the mother's assigned medical group during the first 30 days.

6.2. Enrollment Verification

Member ID cards are not to be used for verification of eligibility or benefits. Provider must verify the

member's WHA eligibility and benefits at the time of each service to ensure accurate claims processing. WHA maintains a system to allow contracted providers, facilities and downstream providers the means to verify member eligibility throughout the business day. Eligibility must be verified using internal tools updated utilizing eligibility data supplied by WHA to our partners, our online provider portal found on our website, EDI 27x processes, or by calling Western Health Advantage.

- WHA's electronic eligibility files are received by each CMG/IPA at least twice a month.
- Members enrolled can be verified by calling the WHA Member Services Department Monday through Friday, 8 a.m. to 6 p.m. at (916) 563-2250 or (888) 563-2250.
- Providers with a log-in ID and password can verify member eligibility in real time on the WHA website at westernhealth.com. If you do not have a log-in ID you can register for one. If you have lost your password, you can reset the password on the website.
- EDI 270/271 transactions are available via our Change Healthcare Payer ID: WSTHA

6.3. PCP Assignment and Changes

In accordance with state law, WHA members may be assigned to the contracted PCP of their choice within the health Plan service area. Members may change their PCP upon request, within the limits as set forth in the *"PCP Assignment"* policy and procedure. New members who fail to choose a PCP or make a faulty PCP selection (such as an adult selecting a pediatrician) will be assigned a PCP in accordance with the policy. PCP changes within the same medical group are granted in almost all cases. Other prospective changes of PCP will be granted unless the member is in a course of care as defined in WHA's policy and procedure. Retroactive changes will generally be denied unless certain circumstances exist as set forth in WHA's policies and procedures, including a change to preserve an existing relationship with the requested physician or a change to correct a faulty PCP selection.

Members may not select a family member or individual living in the member's residence as the member's PCP.

6.3.1. Transitioning from Pediatric to Adult Care

Generally, pediatric patients begin transition of care from a Pediatrician to a Family Practice, Internal Medicine or OB GYN Physician between the ages of 19 to 26 years. However, there are chronic conditions that may warrant a patient to continue their relationship and health care services within the pediatric setting.

WHA encourages members and their families to discuss this important transition with their individual physicians, as this decision should be based on each individual's health care needs. To assist in this transition, WHA conducts outreach to members 18 to 26 years suggesting that they transition to adult care.

6.4. Involuntary Re-assignment

WHA has developed a process to ensure that Members are treated fairly when the Plan, the medical group, or an individual PCP identifies a need to re-assign a Member.

WHA considers involuntary re-assignment of a member a significant issue that can occur only after thorough investigation of the case, a series of formal written notifications to the member regarding the behavior that is problematic accompanied by a request for modification, and the allowance of a reasonable length of time for the member to moderate the behavior in question.

Circumstances that may lead to a member's re-assignment include:

- Rude, argumentative or verbally abusive to a physician or their staff
- Physically abusive to a physician or their staff
- Repeated failure to present for treatment at a mutually scheduled time
- Failure to follow the mutually agreed upon plan of care established with their provider/practitioner
- Failure to abide by the terms, conditions and provisions set forth by WHA and as outlined in the Evidence of Coverage (EOC)
- Failure to provide payment, for which they are responsible, for services rendered
- Fraudulent or deceptive behavior in the use of the service of the Plan or permitting fraud or deception by another

WHA has the right of final approval of any member re-assignment requested by a medical group. Assignment to another PCP may take place without WHA's approval, but must meet the criteria set forth in this section and be in keeping with the medical group's policy/procedure governing such re-assignments. Copies of all correspondence sent to a member regarding possible re-assignment must be forwarded to WHA.

Involuntary re-assignments from a medical group or a PCP follow essentially the same process, which consists of the following required elements:

- Thorough investigation of the facts surrounding the unacceptable behavior, followed by a written letter to the member, sent certified mail. The letter must address the specific behavior that requires modification and a request for such modification.
- Sending a second written letter to the member, via certified mail, if the behavior pattern continues following the initial letter. The letter will explain that assignment to another medical group or PCP may occur if the behavior in question is not modified.
- Allowance of a reasonable length of time following the written notifications for the member to demonstrate a change in behavior.
- Sending a third and final letter to notify the member of their re-assignment as a result of failure to modify the behavior. The letter should explain the member's right to file a grievance with WHA or a regulatory agency regarding the re-assignment.
- Maintenance of a file that includes all case documentation, counseling attempts and letters.

WHA's Member Services Department will track and monitor re-assignment information through the Call Tracking System. An analysis of the data generated will be used to identify quality improvement opportunities.

6.5. Grace Periods

The Department of Managed Health Care require a 30-day, unpaid grace period at the end of a period of nonpayment of any group or individual subscriber. Please note members are still responsible for the premiums due during their grace period.

In addition, federal law requires Qualified Health Plans to allow Exchange members receiving a federal subsidy a 3 consecutive months grace period, the first 30 days of which coincide with the grace period

mentioned above. WHA is required to allow subsidized members to reinstate back to the date of termination upon payment of unpaid premiums. These members are officially “suspended,” and will appear as “terminated” on eligibility files and reports, but will have the right to reinstate as described above.

7. Member Services / Appeals and Grievances

7.1. Member Information

WHA provides written information**/**materials to members to help them understand the Plan’s policies and procedures, their benefits, and how to access health care services. The *Personal Benefits Kit*, *Member Guidelines Booklet* and the appropriate co-payment summaries are sent to all new enrollees. Annually, all enrollees receive an updated *Member Guidelines Booklet* and quarterly, members receive the member magazine. Members also have access to member-specific information on the WHA website. In some circumstances members may receive special mailings to convey important information on health plan processes, activities or changes.

7.2. Member Services

WHA strives to provide exceptional customer service to members and network providers. All provider and member inquiries should be directed to WHA’s Member Services Department. Member Services representatives are available by calling (916) 563-2250 or toll-free at (888) 563-2250, Monday through Friday between 8 a.m. and 6 p.m.

Members and providers can submit general inquiries via email and a WHA representative will respond within one (1) business day. To submit an email inquiry please visit WHA’s website and click on “Contact Us.”

If a member has a dispute or a complaint, an electronic version of the Grievance Form is available in English or Spanish on the WHA website. A printable and hard copy of the form can also be obtained on the WHA website, by calling, or writing to WHA Member Services. Additionally, WHA providers should maintain a supply of and provide members a copy of the Plan’s grievance form upon request. The Grievance Forms are included as Appendices 7 and 8 of this manual. Completed forms should be mailed or faxed to:

Western Health Advantage

Attention:

Appeals and Grievances Department

2349 Gateway Oaks Drive, Suite 100

Sacramento, CA 95833

Fax: (916) 563-2207

To facilitate greater communication between patients and providers, WHA will:

- Upon the request of a member, disclose factors such as methods of compensation, ownership of or interest in health care facilities that can influence advice or treatment decisions; and
- Ensure that provider contracts do not contain “gag clauses” or other contractual mechanisms that restrict the health care provider’s ability to communicate with or advise

patients about medically necessary treatment options.

7.3. Cultural and Linguistically Appropriate Services

WHA is committed to delivering culturally and linguistically appropriate services (CLAS) to all members. Many factors can affect how an individual accesses care, and/or receive or understands information. Patients of different ages, language preference, sexual orientation, gender identifications, preferred pronouns, religions, disabilities, race, ethnicities, and cultures, along with other socioeconomic factors, all have different needs and may interpret interactions with health care professionals differently.

WHA and its clinical providers must be sensitive to both the cultural and language differences of their members, including the cultural variation in the management of disease. Such differences may create mistrust, misunderstanding, a lack of compliance, or other factors that negatively influence clinical situations and impact patient health outcomes. Race, ethnicity and language are collected at enrollment and other touchpoints to help WHA meet our members' needs. WHA also expanded the ability to collect a member's sexual orientation, gender identification, and preferred pronouns in 2023.

WHA complies with all laws and standards for cultural and linguistic services, including but not limited to the Americans with Disabilities Act (ADA), the Affordable Care Act and its implementing regulations, the California Health and Safety Code, regulations promulgated by the California Department of Managed Health Care (DMHC), other applicable federal and State requirements, and the accreditation standards of the NCQA.

Language Assistance and Translation Services

WHA's Language Assistance Program (LAP) WHA offers a variety of interpretation services in over 150 languages as well as written translations or alternative formats, at no cost to the member. Additional communication resources such as audio translation, ASL interpreters, and braille are available for members with hearing, speech or vision loss or impairment. Members who have limited English proficiency, are deaf or hard of hearing, or are blind or low vision may need interpreters or other assistive devices. Members can call 888-563-2250 or 711 for TDD/TTY services.

As a reminder, members with limited English proficiency shall not be required to rely on an adult or minor child to interpret, except in an emergency or if the individual with limited English proficiency specially requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances. (CA HSC §1367.04(b)(4)(C)(i)). Each member's language preference is available as part of the eligibility verification provided to providers on their secure portal of WHA's website.

WHA holds its providers accountable to provide interpretation services in the member's preferred language and/or appropriate assistive technology, as needed. Providers should first utilize the cultural and linguistic services offered by their medical group/IPA. If those resources are not available, provider should utilize WHA's resources.

For detailed information about WHA's Language Assistance Program, how to access interpreter services, ***WHA's Cultural and Linguistic Resources Guide***, and DHHS and HICE education and

resources, visit **mywha.org/LAP**. Additional information, including a detailed description of provider responsibilities, can be found in WHA's Clinical Provider Handbook.

7.3.1. Language Assistance Program (LAP)

Federal and state law require health plans to provide language assistance and assistive technology services at no cost to their members. Appendix 8, "Language Assistance Timeliness Standards", outlines the statutory requirements for providing language assistance and WHA's standards for compliance. Further descriptions of the requirements follow.

7.3.1.1 Phone Interpretation Services

Interpretation is the act of listening to something spoken or reading something written in one language and expressing it in another language orally, accurately and with appropriate cultural relevance. Providers should utilize the services offered by their contracted medical group (CMG/IPA). If those services are unavailable or insufficient, WHA contracts with the multiple language service vendors to provide phone interpretation services for members needing assistance. Video Remote Interpretation (VRI) may also be available upon request from the selected vendor.

For helpful information on phone interpretation services offered by WHA, including American Sign Language and Relay services, please review the "WHA Cultural & Linguistic Resources Guide for Providers, available at https://www.westernhealth.com/pdfs/provider-downloads/secure/wha-cultural-linguistic-resource-guide-for-providers/.

Additionally, WHA provides a TTY/TDD line at 888-563-2250 or 711 for hard of hearing or speech impaired members.

7.3.1.2 In-Person Interpretation Services

It is the policy of the Plan to use phone interpretation services whenever possible. Requests for in-person interpreters should be forwarded to WHA's Member Services Department. Such requests will be handled on a case-by-case basis. Requests for American Sign Language (ASL) services should also be directed to the WHA Member Services Department.

7.3.1.3 Translation Services

Translation is the replacement of written text from one language to the equivalent text in another language. All standardized and enrollee-specific written materials falling under the category of vital or significant documents must be translated and made available in the Plan's threshold language(s). Vital documents include but are not limited to:

- Applications
- Consent forms
- Letters containing eligibility information and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal Notices about the availability of and how to access free language assistance and

Translated documents shall not include a health care service plan's explanation of benefits or similar

claim processing information that is sent to enrollees, unless the document requires a response by the enrollee. Based on census data for the WHA service area and a survey of members, Spanish is the Plan's threshold language. WHA sends standard vital documents in Spanish to members who have indicated it as their preferred written language. Non-standard letters and information that contain vital enrollee-specific information that are sent to WHA members in English must include the Notice of Language Assistance (NOLA) as required by federal and State law. Appendix 12 contains the required NOLA and Appendix 13 contains the required NOLA in Spanish.

The procedures for requesting translation of an English document are as follows: Member Requests

a. Members should contact WHA Member Services as indicated in the NOLA. The Plan will coordinate all translation requests and maintain a log for audit purposes.

b. Member Services will offer to interpret the document over the phone, using the language services vendor or qualified in-house interpreters, as appropriate. If the member prefers to receive a written translation of the document, Member Services will obtain a copy and initiate the translation process.

CMG/IPA Requests

c. Requests for a translation of a non-urgent vital document received from a medical group must be provided to Plan within two (2) business days of notification of request for translation from the member. Urgent documents must be provided by the CMG/IPA to the Plan within one (1) business day of notification.

d. Medical groups should keep a log of the date the request was received and when the document was provided to the Plan.

e. The Plan will provide the member an oral interpretation or written translation of the document within 21 days for non-urgent and seventy-two (72) hours for urgent requests.

7.3.1.4 Provider Responsibilities for Language Assistance

In addition to the above, providers are responsible for the following:

a. Member Informing/Signage

Providers must inform members of the availability of language assistance services. This may be accomplished by posting a multilingual sign in areas likely to be seen by members or providing the NOLA in Appendix 12 and Appendix 13 to WHA members.

b. Use of Appropriate Interpreters

- Interpreter services, including TTY lines services, VRI, or in-person as needed, must be offered at the time of appointment scheduling and for scheduled appointments. ASL must be provided for scheduled appointments.
- Providers must not require or suggest that members with limited English proficient (LEP), or who are deaf or hard of hearing, provide their own interpreters or use family members, particularly minors, or friends as interpreters. If a member insists upon using the family or friend as an interpreter after being informed of the availability of language assistance services, the provider should document this choice in a prominent place in the member's medical record.

- Bilingual staff and providers assisting members in another language must have a completed HICE Employee Language Skills Self-Assessment Tool on file with the medical group/IPA that rates their skills in the other language as level 3 or above to meet the Plan's proficiency standards. The tool is available in the HICE provider tool kit, "Better Communication, Better Care – Provider Tools to Care for Diverse Populations" (https://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284).

c. Adequate Accommodation

Provider offices should be equipped to facilitate the use of interpretive services in multiple ways. Examples include additional phones for three-way calling, dual handset phones or speaker phones.

d. Confidentiality

Providers and their staff must take steps to maintain patient confidentiality when using an interpreter. This includes private areas for three-way calling or for conference/video calls using a speaker phone.

e. Updating Member Records

Providers and their staff should ascertain a member's need for language assistance at the time the appointment is made or when the member appears for services, and document this information in the member record.

f. After-Hours Linguistic Access

Providers are encouraged to accommodate members with limited English proficiency by having multilingual messages on answering machines and training their answering services and on-call personnel on how to access interpreter services after hours.

g. Provider Directory Updates

Providers must notify WHA of changes in the language capabilities of medical staff at their offices so that this information is up-to-date on the WHA website and in the printed provider directory.

At least annually WHA performs an assessment of members' cultural and linguistic needs and WHA's capacity to meet those needs. This information is reviewed by the Quality Improvement committee ("QIC") for purposes of identifying potential quality improvement opportunities and is shared with WHA's CMGs/IPAs.

Questions regarding the language assistance program should be directed to WHA's Compliance and Ethics Department at LanguageAssistance@westernhealth.com.

8. Pharmaceutical Management

WHA's Chief Medical Officer (CMO), Assistant Medical Directors, Pharmacy Director and Clinical Pharmacists are primarily responsible for ensuring effective pharmaceutical management for WHA members. WHA promotes optimal therapeutic use of pharmaceuticals through the participation of pharmacists and physicians on its Pharmacy & Therapeutics (P&T) Committee, which meets every quarter.

OptumRx is WHA's contracted pharmacy benefit management (PBM) company and has been delegated responsibility for claims processing and the retail pharmacy network. Plan staff processes both provider and member appeals related to pharmacy benefit issues. For general information about OptumRx services, see their website: https://www.westernhealth.com/pharmacy-information/

8.1. Pharmacy and Therapeutics Committee (P&T)

WHA's Pharmacy Director chairs the P&T Committee and WHA's Pharmacy Technician serves as the Committee's secretary. The WHA CMO, Pharmacy Director, and WHA Clinical Pharmacist maintains ongoing communication with the PBM's clinical representatives and an OptumRx pharmacist is a non-voting member of the P&T Committee.

WHA's pharmaceutical management procedures and the Preferred Drug List (drug formulary) are developed by clinicians and pharmacists who are voting members of the P&T Committee. Decisions are based on sound clinical evidence published in peer reviewed journals, supported by national treatment guidelines, and the clinical expertise of the P&T Committee members. If Preferred Drug List decisions require additional input, the P&T Committee will solicit the expertise of specialists who are not committee members.

Pharmaceutical policies and procedures are reviewed annually, updated periodically as necessary, and are presented to the P&T Committee for review, input and approval.

The role of the Pharmacy & Therapeutics Committee is to:

- Determine the Preferred Drug List (PDL) status and coverage of drugs, devices, and supplies;
- Ensure adequate representation of drugs on the PDL from all appropriate therapeutic categories;
- Establish policies and procedures to ensure that the efficacy, safety and quality of drug products utilized and available on the WHA PDL are consistent with clinical analyses and/or peer reviewed data;
- Review and monitor pharmacy performance indicators to identify trends and/or areas for improvement;
- Design action plans as necessary to improve performance;
- Measure performance improvement and report results to appropriate oversight committees;
- If there is more than one medication in a drug category with similar efficacy and safety profiles, review for cost- effectiveness;
- Review new FDA approved drugs for appropriate tier placement consideration on the preferred drug list;
- Determine the need for required prior authorization or other utilization controls and approve prior authorization criteria; and
- Ensure a process is in place to identify and notify members and prescribing practitioners affected by a Class I or II drug recall.

8.2. Preferred Drug List

WHA's Preferred Drug List (PDL) is based on a multiple tier incentive design. Most commonly, the PDL lists generic drugs with a first-tier copayment and preferred brand name drugs with a second-tier copayment. Non- preferred Brand name drugs have a third-tier copayment. Most commonly, oral and self-injectable specialty drugs are listed on the PDL. Injections, except for insulin are covered under the medical benefit. Oral specialty drugs are most often Tier 3 for large group members and Tier 4 is for all ACA plans including Off-exchange SG and individual members. Most Specialty drugs require prior authorization and are limited to up to a 30-day supply at a specialty network pharmacy. Specialty network pharmacies include OptumRx Specialty Pharmacy for mail order, the outpatient pharmacies of UC Davis and NorthBay, and St. Joseph's

McAuley pharmacy of Dignity Health. The PDL is available to members and providers on the WHA website. The PDL identifies drugs with quantity limits and prior authorization or step therapy requirements.

8.3. Generic Substitution

WHA requires the generic product be dispensed for all multi-source brand name drugs unless the physician specifies “dispense as written” (DAW). DAW requests must comply with all regulations of the California Board of Pharmacy.

8.4. Prior Authorization

There are drugs on the formulary that require prior authorization such as specialty drugs. If prior authorization is required, requests should be submitted directly to WHA. Some drugs may require Step Therapy for coverage consideration.
Please note that State law now requires prescription prior authorization requests to be completed on the standardized Prescription Drug Prior Authorization Request Form (Form No. 61-211 (12/16)), which can be obtained in the Provider section of the WHA website, from OptumRx, from the Department of Managed Health Care website here:
https://www.westernhealth.com/pdfs/provider-downloads/prior-auth-request-form/

, in Appendix 11 to this document, and in many EHR systems. For expeditious processing, please ensure all material information regarding the request is included on and with the form, including relevant medical records and/or lab documentation if guidelines require. The request must be processed within twenty-four (24) hours of receipt for exigent/urgent and seventy-two (72) hours of receipt for nonurgent requests. ”Exigent” means that a Member is suffering from a health condition that may seriously jeopardize the Member’s life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-preferred drug. If no response is received within these timeframes, it is deemed approved for the duration of the prescription.

Effective July 1, 2023, and in accordance with the requirements under Health and Safety Code section 1367.207, WHA shall not do any of the following:

1. Deny or delay a response to a request for the purpose of blocking the release of information related to a request by an enrollee or provider for the enrollee’s eligibility for a prescription drug, the most current formulary, cost-sharing information for the prescription drug or alternatives, or applicable utilization management requirements for the prescription drug.

2. Restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing to an enrollee the information in number (1) above, additional information about lower cost or clinically appropriate alternative drugs, whether or not they are covered under the enrollee’s health care service plan contract, or information about the cash price of a drug.

3. Except as required by law, interfere with, prevent, or materially discourage access, exchange, or use of the information provided pursuant to number (1). This includes charging fees for access to the information, not responding to a request at the time made consistent with this section, or instituting enrollee consent requirements.

4. Penalize a prescribing provider for disclosing the information provided pursuant to number (1).

5. Penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

8.4.1. Prior Authorization for Self-Injectables

Most self-injectable medications require prior authorization for coverage. Fax authorization requests directly to Western Health Advantage (using the Form No. 21-211 (12/16)) described above) at WHA Pharmacy PA Fax Number: 916-568-5280**.** Prior authorization requests for physician/office-administered injectable medications may be considered under the medical coverage and are reviewed directly by the Medical Groups' Utilization Management Nurse or Clinical Pharmacist for coverage determination.

8.5. Off-Label Use

WHA allows the approval of the off-label use of drugs if the criteria below are met. WHA recommends that the Medical Groups' Utilization Management department review the request prior to submission to the WHA Clinical Pharmacist for review and coverage determination. All potential coverage denials must be reviewed by WHA's Clinical Pharmacists, Assistant Medical Director or Medical Director. Factors to be considered for approval include, but are not limited to:

For diagnosis of off-label non-FDA approved indication(s):

- The drug has been approved as safe and effective by the FDA for at least one indication, **AND**
- Preferred drugs for the condition have failed to achieve therapeutic goals, are contraindicated, or caused unacceptable side effects, **AND**
- The drug is prescribed by a participating (PAR) provider for a life-threatening condition, or a chronic and seriously debilitating condition, for which no other drug or therapy exists, **AND**
- Patient meets one of the following:
    - Diagnosis is supported as a use in American Hospital Formulary Service Drug Information (AHFS DI), **OR**
    - Diagnosis is supported as a use in the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B, **OR**
    - Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of Class I, Class IIa, or Class IIb, **OR**
    - Diagnosis is supported as an indication in Clinical Pharmacology, **OR**
    - The use is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed off-label use as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

8.6. Vacation Supply of Medication/Lost Medication

WHA allows the approval of a 30-day supply of medication to cover a patient's vacation. The dispensing pharmacy can approve a 30-day vacation override once every calendar year by entering the appropriate code into the claims adjudication computer system. More than one request per year will be referred to WHA's Pharmacy Department for review.

All requests for controlled substances will be referred to Medical Management for review before a vacation override is authorized. Requests for early refill of controlled substances must be approved by the prescribing physician and a prior authorization form submitted to WHA Pharmacy Department for review.

Replacement medications for improperly stored, damaged, lost or stolen drugs are not covered.

Section 1367.207(b):
(b) A health care service plan shall not do any of the following:
(1) Deny or delay a response to a request for the purpose of blocking the release of information pursuant to subdivision (a).
(2) Restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing to an enrollee any of the following:
(A) The information provided pursuant to subdivision (a).
(B) Additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the enrollee's health care service plan contract.
(C) Information about the cash price of the drug.
(3) Except as required by law, interfere with, prevent, or materially discourage access, exchange, or use of the information provided pursuant to subdivision (a). "Interfere with, prevent, or materially discourage access, exchange, or use of the information" includes charging fees for access to the information, not responding to a request at the time made consistent with this section, or instituting enrollee consent requirements.
(4) Penalize a prescribing provider for disclosing the information provided pursuant to subdivision (a). For purposes of this paragraph, "penalize" includes an action intended to punish a provider for disclosing the information set forth in subdivision (a) or intended to discourage a provider from disclosing this information in the future.
(5) Penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug. For purposes of this paragraph, "penalize" includes an action intended to punish a provider who has prescribed, administered, or ordered a lower cost or clinically appropriate alternative drug, or intended to discourage a provider from prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug in the future.

8.7. Samples and Manufacturer's Coupons

Drug samples are prescription medications packaged as one or more dosage units by a manufacturer or distributor in accordance with Federal and State statutes. Drug samples are provided by a pharmaceutical company to a licensed practitioner free of charge. A drug sample is not intended to be sold and is intended to promote the eventual sale of the drug.

Manufacturer coupons are programs funded by pharmaceutical manufacturers of a prescription drug, which helps to lower the out-of-pocket cost that the patient pays at the pharmacy.

Samples and manufacturer's coupons do not count toward step therapy requirements are not considered for continuation of therapy for the purposes of a prior authorization review.

9. Provider Services

9.1. Provider Information

It is the responsibility of each CMG/ IPA to notify WHA immediately when a new practitioner has been contracted or terminated as a WHA participating provider. In the case of a newly contracted practitioner, the CMG/IPA must submit a new provider profile form to the Plan that includes all the required information including the provider email address, race, ethnicity, and language (see Appendix 10). Please note that all board certifications must include the precise name of the board certification from the ABMS (or other) board, as well as the effective and expiration dates. In the case of a provider termination, the CMG/IPA must inform WHA immediately by contacting WHA's Provider Relations Department.

WHA mails a Clinical Provider Handbook within ten (10) days of the effective date of a new direct provider contract. The handbook includes a Welcome Letter, key policies and procedures, and other provider materials. WHA distributes provider orientation materials through the contracted medical groups, or directly to the providers, as applicable.

WHA's CMGs/ IPAs are responsible for educating their contracted practitioners/providers regarding the medical group/IPA policies and procedures related to providing care and services to WHA members.

WHA will not discriminate against a licensed provider solely on the basis of a civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

Information and resources for providers are also available on the WHA website. Providers may request a policy/procedure not available on the website or obtain clarification regarding a specific policy/procedure by calling Member Services at (916) 563-2250 or (888) 563-2250.

9.2. National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require national standards for electronic health care transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique NPI.

All HIPAA-covered health care providers, whether they are individuals or organizations, must obtain an NPI for use in identifying themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA-covered entities, such as providers completing electronic transactions, healthcare clearinghouses and large health plans, must use only the NPI to identify covered healthcare providers in standard transactions. All HIPAA standard transactions must include NPIs. No legacy identifiers (other than the billing provider's tax ID number on claims and ERAs should be included on HIPAA standard transactions. Non-compliant transactions will be rejected.

Every participating provider and facility is required to submit to WHA its NPI codes that have been

assigned by or registered with the NPPES. WHA CMGs/IPAs are responsible to submit all NPIs directly to WHA on behalf of all of their respective participating providers.

9.3. Provider Data

From time to time, WHA may transmit information about its participating physicians to external parties for search engines or other programs that enhance the ability of WHA members, prospective employer groups or prospective members, brokers and others to ascertain whether a particular physician participates in WHA's provider network. The information WHA may share includes name, race, ethnicity, gender identification, specialty, hospital and medical group affiliations, board certification, languages spoken, office locations, and whether or not the physician's practice is accepting new patients. If a CMG/IPA wishes to limit the use of its physician demographic information in this way, the CMG/IPA may contact Member Services and ask to speak with a Provider Relations representative.

WHA has partnered with Quest Analytics (Formerly known as BetterDoctor) to keep our provider directories up-to-date and compliant with state and federal regulations. Every quarter, your practice will receive a fax, post letter, email or phone call from Quest Analytics asking you to update your information online. Please respond to quarterly verification requests from Quest Analytics. This is an easy way to update your information with WHA without any administrative burden.

California law requires providers to verify their practice information with any health plan they contract with. Compliance with the law ensures that patients won't be misdirected to inactive practices or providers.

In California, Senate Bill 137 mandates health plans reach out twice a year to networked providers to gather updated information. Failure to update information in accordance with California law can result in plans delisting from the provider directory, and/or delaying payment or reimbursements of claims.

If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate within 30 business days, the plan shall take no more than a week to verify whether the provider group/PBM information is correct or requires updates. If the Plan is unable to verify the information is correct or requires updates, the provider/PBM shall be removed from the provider directory after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.

Email validation@betterdoctor.com to reach Quest Analytics or you can contact WHA's Provider Relations Department. You may also email directory@westernhealth.com to report any inaccuracies in WHA's provider directory.

9.4. Provider Complaints

Providers have the right to appeal directly to WHA when dissatisfied with the initial adverse determination of a delegated medical group, IPA or hospital when the issue is related to medical necessity or utilization management. Such appeals must be made within sixty (60) working days of receipt of the written determination by submitting a dispute to the WHA provider dispute resolution (PDR) system. All providers directly contracted with WHA shall utilize WHA's Provider Dispute Form located in Appendix 9 of this manual or the electronic version, which is available on the provider pages of the WHA website.

To file multiple similar disputes, a provider must do the following:

- Sort the disputes by similar issues;
- Place a numbered cover sheet on the top of each batch; and
- Include a cover letter for the entire submission that describes each dispute with references to the numbered cover sheets.

All provider disputes must be submitted in writing to: Western Health Advantage

Attn: Claims - PDR

2349 Gateway Oaks Drive, Suite 100

Sacramento, CA 95833

Disputes shall be received, handled and resolved by WHA without charge to the provider. WHA and WHA's delegated providers are under no obligation to reimburse a provider for costs incurred in connection with utilizing the PDR process. Provider disputes will be acknowledged within fifteen (15) working days of receipt for all written PDRs and within two (2) business days for all PDRs submitted electronically. Written determinations will be sent within forty-five (45) working days of receipt, unless additional information is needed and requested. Payment on a claim dispute decided, in whole or in part, on behalf of the provider will be issued within five (5) working days of the written determination. Payment will be calculated beginning forty-five (45) working days from the receipt date of the original complete claim and includes applicable interest and penalties.

WHA and its delegated groups are responsible for ensuring that an appropriate provider/practitioner appeal process is in place and followed per regulatory requirements. Provider appeals for both contracted and non-contracted providers are generally handled by WHA's delegated entities *unless:*

1. the initial adverse determination was issued by WHA for an out-of-area emergency admission, non- network second opinion request, or for another request/service for which WHA has financial risk; or

2. the initial adverse decision was issued by a delegated group and related to a medical necessity or UM decision, in which case the provider may request an appeal at the Plan level and bypass the group's appeal process.

If a provider appeal is processed and upheld at the group level, the provider may ask for a second appeal or reconsideration at the Plan level if the denial involves medical necessity or a UM-related service. Plan level provider appeals are handled through WHA's Claims Department. For details, see WHA's policy and procedure titled "*Provider Dispute Resolution",* which is available on WHA's website. Please contact Member Services at (916) 563-2250 or (888) 563-2250 with questions.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-563-2250, TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained

unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

9.5. Contract Termination

9.5.1. Medical Group Termination

Termination of medical group contracts must be accomplished in accordance with the terms of the applicable group provider agreement and applicable laws and regulations, including the Block Transfer regulation, 28 CCR 1300.67.1.3, which governs the member notice and timing thereof.

WHA will comply with all applicable standards regarding access and availability of services by transferring members to a new provider group near where the member lives or works so that care is not unduly interrupted and access to medically necessary services is preserved. Best efforts will be made to link the member to the same specialty as their previous provider.

WHA's member letter will inform the member of their practitioner and/or CMG/IPA affiliation change and inform them of their option to select a new network provider of their choice if they do not want the one assigned.

9.5.2. Individual Practitioner Termination

If an individual participating practitioner terminates their contract with a CMG/IPA, the medical group must notify WHA as soon as possible, at least 45 days prior, so that WHA may notify all members assigned to the terminating practitioner. As required by the NCQA and regulations, all members affected by the termination of a practitioner will be notified at least thirty (30) calendar days prior to the effective termination date. In the event that WHA does not receive timely notification, WHA will notify the affected members within seven (7) days of receipt of notice from the medical group/IPA. Each member assigned to the terminated practitioner will be offered an opportunity to select any participating PCP or to follow the terminated practitioner to the new contracted medical group/IPA, if applicable. If the member does not respond to any such inquiry about their assignment, the member will be auto-assigned to a practitioner within the existing CMG/IPA, based on instructions received from the existing medical group/IPA. WHA will make its auto assignments based on the guidelines set forth in its *"PCP Assignment"* policy and procedure.

If an individual WHA participating specialist terminates their contract with a CMG/IPA, the medical group/IPA has responsibility for notifying members who have been under the ongoing care of the specialist of the termination of the specialist and the member's alternative options. In the event that an entire medical group/IPA terminates its contract with WHA, it is WHA's responsibility to notify members of the specialist's termination as set forth above under the Medical Group Termination section.

9.5.3. Termination for Cause by WHA

WHA may initiate termination of a medical group or individual practitioner according to its policies and procedures for cause. Examples of causes for termination can include, but are not limited to:

- Balance billing of members for amounts other than applicable copayments
- Failure to maintain privileges at a participating hospital
- Failure to respond to requests for credentialing information
- Failure to maintain required levels of malpractice insurance
- Failure to respond to requests for corrective action
- Failure to provide adequate access
- Failure to maintain adequate facilities
- Repeated unjustifiable referral of WHA members to non-participating providers and Medical quality issues.

9.5.4. Corrective Action Program

Providers are required to cooperate with WHA's Corrective Action Program (CAP) as described in COMP-003 Policy, which is summarized below, and can be found on WHA's Provider portions of its website.

WHA is committed to providing a level of oversight of its contracted medical groups/IPAs/hospitals that ensures appropriate compliance with obligations under group or government contracts, applicable state and federal laws and regulations, and applicable accreditation requirements. WHA employs a Corrective Action Program that assures Providers are given fair notice of deficiency and, where appropriate, an opportunity to correct a deficiency.

Providers who demonstrate significant deficiencies shall be notified in writing, and a Corrective Action Plan will be requested to be received within thirty (30) calendar days of the letter date.

A Provider who does not respond to the first notice of deficiency or does not demonstrate compliance within one (1) month is sent a second notice of deficiency. As appropriate, the second notice may inform the Provider of possible sanctions or consequences, including, for example, freezing enrollment, revocation of delegation, breach of contract actions, or other applicable sanctions.

Providers who do not respond to the second notice or do not submit an acceptable CAP within thirty (30) calendar days may be sent a third notice or if, in the judgment of the Chief Compliance Officer, a third notice would not result in a successful outcome, may be sent a final notice. The final notice shall notify the provider of the particular sanctions that are being implemented and the timeline in which the sanctions will be implemented.

If a Provider continues to be out of compliance and the sanctions do not resolve the issue, WHA may consider termination of the contract or other legal or contractual remedies. The specific process shall be in accordance with the provider contract and may be established in each case with advice from legal counsel.

At each stage in the process, a Provider who submits a CAP shall be notified in writing if the CAP is acceptable. The Provider's progress toward completing the CAP shall be monitored and, depending on the type of deficiency, the Provider may be subject to a follow-up focused audit prior to closure of the CAP. When it has been determined that the deficiency has been remedied and approved, the CAP shall

be closed and the Provider shall be notified in writing that the issue has been resolved to the satisfaction of the Plan.

Providers who fail to respond, to correct identified deficiencies or to submit an acceptable CAP may be subject to possible sanctions; or in acute situations, WHA may consider termination of the contract or other legal or contractual remedies.

9.6. Concierge Practices

Generally, WHA does not permit practices known as “concierge,” “retainer” or “boutique” practices (referred to here as “Concierge”) to participate in WHA’s provider network if the network provider is including Crossover Services in the Concierge Practice. A Crossover Service is a service provided by a network provider to which the patient may be entitled, based on the concierge fee, but which is the same as or similar to a service the patient may have been entitled to under the terms of WHA’s health plans. Examples include but are not limited to requiring concierge fees for access to appointments at particular times of the day (e.g., morning appointments), access to physical exams, and other services.

If WHA becomes aware that a participating network provider is a Concierge practitioner, WHA will require the medical group/IPA to investigate whether the practitioner is offering Crossover Services under the Concierge arrangement. WHA may require that the medical group/IPA terminate the provider from participation in WHA’s provider network. This policy applies regardless of whether the Concierge practice includes or excludes WHA members from the Concierge program, unless WHA members are given all of the Concierge services that are available to paying patients, at no charge.

9.7. Other Provider Issues

Downstream provider contracts are required to comply with all aspects of the Knox-Keene Act and regulations of the DMHC, and other federal and state laws. If a CMG/IPA is required to amend its contracts in compliance with the Knox-Keene Act or another law, each medical group/IPA must document its actions with respect to revising its contracts and shall make the documentation available to WHA upon WHA’s reasonable request.

If a medical group/IPA refers a Member to a non-network provider, the medical group/IPA must assure that the provider is aware of and only charges the correct cost-sharing amount.

10. Quality Management

WHA’s quality management program integrates quality improvement (QI) tenets with the structure and processes necessary to improve health outcomes and member satisfaction. WHA attempts to meet its quality goals through collaborative relationships with its contracted providers, continuous QI activities and the leveraging of best practices throughout its provider network. WHA strives to maximize customer service by offering a competitive array of products, consistent systems and processes, and by providing ongoing education to employees regarding their individual roles related to QI. WHA holds a National Committee for Quality Assurance (NCQA) accreditation status and Multicultural Health Care Distinction for both Commercial and Exchange memberships.

Annually, WHA collects and analyses data to assess its performance related to NCQA’s criteria as follows: 1) For Commercial membership the Healthcare Effectiveness Data and Information Set (HEDIS) and NCQA’s Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction survey are required and 2) For Exchange membership the Exchange Quality Rating System (QRS) HEDIS Measure Set

and Qualified Health Plan (QHP) satisfaction survey are required. The findings from those studies and the analysis of member/provider complaints and appeals will identify opportunities to improve the care and service provided to WHA's members.

The QI activities WHA targets for action are often initiatives that are required by a regulatory or accrediting agency. When selecting other QI projects or activities the Plan takes into consideration issues that affect the largest number of members, issues that are of high significance to members, and issues that have the potential for making significant improvement. Many of WHA's QI activities are carried out in collaboration with the Plan's contracted MGs/IPAs.

10.1. Quality Improvement (QI) Program

10.1.1. Purpose

The primary purpose of WHA's QI Program is to provide the framework, through its structure and processes, to continuously identify and improve clinical quality, maximize safe clinical practices, and enhance member and provider satisfaction.

The QI program strives to ensure that services provided to WHA members conform to the standards and requirements of accrediting and regulatory agencies including the NCQA, California's Health Benefits Exchange, also known as "Covered California" and the DMHC, among others.

WHA is committed to the integration of QI activities across its care delivery network and the involvement of network providers/practitioners in that process. The single most important factor supporting this integration is the multidisciplinary makeup of WHA's Quality Improvement Committee (QIC), the body responsible for oversight of WHA's QI program. QIC members include a team of network primary and specialty care physicians, a behavioral health physician, WHA's Chief Medical Officer (CMO), Medical Director, Assistant Medical Director, Clinical Pharmacist and representatives from WHA's Quality, UM, Population Health Management Manager, Member Services, Appeals and Grievances, and Provider Relations Departments. Network UM/QI leaders attend meetings as able and collaborate informally with WHA staff on a frequent basis.

10.1.2. QI Program Scope

Responsibility for QI and the QI Program resides with WHA; however, specific QI functions are delegated when appropriate. WHA delegates utilization management, case management, complex case management, credentialing, medical record/health information management and claims processing to its CMGs /IPAs. The QI Program applies to all providers and practitioners who offer contracted or non-contracted services to WHA members. Provider contracts address the expectation that providers/practitioners will be involved in the QI Program and support WHA's quality improvement processes, policies and procedures. Practitioners from each of WHA's contracted medical groups/IPAs are currently involved in the planning, development, implementation and review of QI Program activities. The QI Program requires that no physician or individual involved in QI, UM or risk management have direct responsibility for the review of any case (for quality of patient care or appropriate utilization of resources) in which he/she is professionally or personally involved.

The QI Program encompasses services provided in the following areas:

- Inpatient settings including hospitals, skilled nursing facilities, residential and sub-acute facilities, behavioral health/chemical dependency facilities;
- Outpatient settings including home health, diagnostic services, clinical laboratories, ambulatory

surgery centers, pharmacies, pediatric dental services and behavioral health/chemical dependency related services;

- Primary care, high-volume specialty care, and behavioral health care and substance abuse services;
- Utilization management services including routine and complex case management;
- Population Health Management (formerly Disease Management and Wellness Programs) and healthcare related services provided through web-based programs and Nurse Advice Line services.
- Urgent Care Telemedicine services.
- Culturally and Linguistically Appropriate Services.

10.1.3. Contracted Medical Group Participation

WHA's contracted providers are responsible for complying with WHA's QI Program. Physician representatives from the contracted medical groups/IPAs are involved in the QI process and QI Program activities through:

- QIC membership, and if appropriate, subcommittee membership;
- Support of fair and reasonable credentialing decisions;
- Peer review of appeals, grievances and potential quality of care issues;
- Population Health Management program activities;
- Preventive health and clinical practice guideline development and revisions;
- Provision of the practicing physician's input into potential clinical/service QI initiatives and interventions strategies.

10.1.4. QI Program Objectives and Goals

WHA's QI program goals and objectives are linked to the mission and goals of the Plan which focus on providing an environment that enhances the relationship between patient and physician while providing affordable and compassionate health care to members. Quality goals are developed annually to ensure progress toward QI Program objectives.

10.1.5. QI Program Documents

QI Program Evaluation

Annually, an evaluation of WHA's QI Program is conducted to assess the effectiveness of the previous year's QI activities. Results of the evaluation are reported to the QIC and Board of Directors, and are used to determine and prioritize QI activities for the coming year and the development of the QI Work Plan.

QI Program Description

The QI Program Description (QIPD) is a written document that defines the goals, scope, structure, and accountabilities of the QI program. It is reviewed annually and updated as needed, based on current accreditation/regulatory requirements and the results of the annual QI Program Evaluation. The QIPD is reviewed/approved by WHA's QIC and Board of Directors.

QI Work Plan

The QI Work Plan is developed annually, with input from WHA's functional areas and the QIC. It outlines the initiatives to be undertaken to improve care and service to WHA members. The QI Work Plan is considered a dynamic document that states time frames in which activities should be achieved and person(s) responsible. It is revised and updated as needed. The QI Work Plan is reviewed/approved by WHA's QIC and Board of Directors.

10.2. Authority, Accountability and Responsibility

WHA's Board of Directors has ultimate authority, accountability, and responsibility for WHA's QI Program. The Board has delegated the program's day-to-day operations to WHA's CMO with oversight by the QIC.

Information flows to and from the Board of Directors through the CMO and the QIC's quarterly reports to the Board.

10.3. Quality Improvement Committee (QIC)

WHA's QIC, a staff and practitioner-based committee, chaired by WHA's CMO, meets monthly at least ten (10) times per year. The QIC is responsible for coordinating, directing and overseeing quality activities and initiatives across the Plan. The Committee has the authority to designate subcommittees, task forces, or ad hoc committees to carry out designated quality functions. Signed and dated QIC minutes reflect the actions and decisions of each meeting.

The QIC maintains oversight of the QI Program through a subcommittee structure. The activities of each subcommittee reflect the functional activities of that committee. Quarterly, each subcommittee presents a comprehensive report to the QIC that addresses findings from monitoring and oversight activities, regulatory and NCQA compliance and other relevant activities. The subcommittees are:

- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee

The Compliance Committee reports directly to the Board of Directors. The functional areas related to the QI Program are reported annually to the QIC.

The Quality Experience Workgroup meets bi-monthly and has a focus on improving the member's experience. Projects and activities completed through the workgroup will be reported to the QIC and Board of Directors at least annually.

10.4. Quality Improvement (QI)/Performance Improvement (PI)

WHA's QI activities focus on implementing mandates from regulatory, accreditation or a contractual body, improving HEDIS, M-CAHPS and QHP scores, taking action on QI opportunities identified through oversight activities, routine grievance/appeal monitoring, member/provider feedback and measuring the effectiveness of improvement activities. WHA shares the results of member experience and clinical performance with its medical groups, vendors, practitioners, and providers through various media sources including the WHA website.

10.5. QI Program Functions

10.5.1. Access and Availability Standards and Monitoring

WHA has established access and availability standards for its delivery network which meet the DMHC Timely Access Requirements, and that ensure WHA's provider network has adequate capacity and availability of licensed health care providers to meet those standards and requirements. The Plan assesses organization-wide and practice-specific performance against the standards and the findings are evaluated and reported to the QIC. Corrective action plans are developed, implemented and monitored as needed. WHA's access and availability standards are provided to all new practitioners in the *WHA Clinical Provider Handbook* and are distributed to existing network practitioners and members through various media sources including, but not limited to, the following:

- Provider Manual
- WHA's website
- Member Guidelines Booklet

Timely Access standards reflect the timeliness with which a member can obtain an appointment for covered health care services for routine/regular care, routine specialty care for non-urgent conditions, emergency care, urgent care, after-hours care, behavioral health care, and ancillary services. The standards also define appropriate waiting times for a member to speak with a Plan Member Services and provider's representative.

WHA has established a process and access standards for assessing and ensuring that its health care delivery network has available hospital/emergency/ancillary service providers and practitioners who provide primary care, specialty care and behavioral health care (BH), in sufficient numbers and in an adequate geographic distribution to meet the needs of WHA members. WHA also conducts a Geographic Access analysis to annually monitor all PCPs, all specialists, high-volume and high-impact specialists, and BH specialists in its network by geographic location.

WHA defines PCPs as those practicing in the areas of: Family Practice, Pediatrics, Internal Medicine, and General Medicine. OB/GYN physicians may function as PCPs upon Member request and physician approval, or a Nurse Practitioner or Physician Assistant who works with a Primary Care Physician. Providers specializing in obstetrics and/or gynecology, pediatrics, or internal medicine or Nurse Practitioner or Physician Assistant interested in being designated as a primary care physician, please see your medical group's administrator.

Optum Behavioral Health (OptumBH), WHA's MBHO for commercial members maintains access and availability standards that comply with NCQA and DMHC requirements. OptumBH determines which practitioners serve as BH practitioners and has set quantifiable and measurable standards for the number of such practitioners and their geographic distribution. Quarterly, OptumBH provides access data to WHA and annually they report WHA- specific findings from their Geographic Access Survey to the Plan. WHA analyzes performance against OptumBH's access and availability standards annually.

Access and Availability Standards
WHA's Access and Availability Standards are as seen below and can also be reviewed online: https://www.westernhealth.com/search-for-providers/the-wha-network/timely-access-to-care/

Appointment Type – General Medical	**Timeframe**

Emergency Care	Immediate
Urgent care – no prior authorization required	48 hours
Urgent care – authorization required	96 hours
Non-urgent primary care	10 business days
Non-urgent specialist	15 business days
Non-urgent ancillary services	15 business days
Non-urgent **non-physician mental health care** or substance use disorder provider	10 business days
Nonphysician mental health care or substance use disorder provider (follow-up appointment, non-urgent)	Within 10 business days from prior appointment

Telephone triage and screening services with a health professional*

- Routine/Urgent: Waiting time cannot exceed 30 minutes

Speaking with a WHA member service representative by phone during normal business hours

- Routine/Urgent: Waiting time cannot exceed 10 minutes

Health plans are required by the DMHC's Timely Access to Non-Emergency Health Care Services Regulations ("Timely Access Regulations") to assess appointment availability in their provider networks. Health plans must ensure that appointments for various types of non-emergent care (primary or specialty care) are offered within specified timeframes, in a manner appropriate for the nature of the patient's condition.

If a provider is unable to obtain a timely referral to an appropriate provider, the provider or the enrollee should contact WHA at 916-563-2250 or toll-free 888-563-2250 for assistance.

If the provider is unable to obtain a timely referral to an appropriate provider, the provider and the enrollee may file a complaint by contacting the Department of Managed Health Care:

Toll-Free provider complaint line: 1-877-525-1295 and Toll-Free consumer complaint line: 1-877-466-2219

Appointment Availability Survey

The annual Provider Appointment/Availability Survey (PAAS) of providers by county includes primary care physicians (PCP), specialty care provider (SCP), ancillary provider, and non-physician mental health provider offices to determine compliance with the DMHC Timely Access Regulations regarding access to both urgent services and non-urgent appointments. Surveys may be administered telephonically, by fax, or by email. Responding promptly to all regulatory surveys are required. WHA appreciates the participation of all its CMGs/IPAs in this survey.

Compliance to the standards can be met by the physician or on-call physician, and/or by Nurse Practitioner (NP)/Physician Assistant (PA) when the office is able to offer all appointment types (such

as urgent, routine, sick, etc.) to patients on the same or next business day from the time an appointment is requested, or within the timeframes enumerated by the DMHC specific to the provider type.

Additionally, services offered outside of the timeframe can be compliant if there is a process in place for the physician to: 1) assess the patient's condition to determine whether a longer waiting time will not be detrimental to the patient and 2) notate this decision in the patient's record.

Provider After-Hours Access, Triage & Screening

Under the DMHC Timely Access Regulations, health plans are required to assess after-hours access, triage and/or screening in their provider networks. Health plans must ensure that after-hours triage and screening services are offered within specified timeframes, in a manner appropriate for the nature of the patient's condition.

The DMHC defines "triage" or "screening" as the assessment of a patient's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a patient who may need care, for the purpose of determining the urgency of the patient's need for care. The "triage or screening waiting time" means the time waiting to speak by telephone with the qualified health professional, which shall not exceed thirty (30) minutes.

Provider After-Hours Access Survey

Providers are required to respond promptly to all regulatory surveys. The After-Hours survey assesses the following:

- **After-Hours Appropriate Emergency Instructions:** What would you tell a caller who states he/she is dealing with a life-threatening emergency situation (e.g., sudden onset chest pain)? For example, is the patient told to call 911 or referred to the nearest emergency room? The answer should be "yes."
- **After-Hours Access to a Clinician:** If a patient expresses an urgent need to speak with a clinician, is there a way to put them into contact with the physician, on-call physician, or a health care professional such as an advice nurse? The response should be "yes".
- **After-Hours Provider Timeliness**: In what timeframe can patients calling after-hours expect to hear from the provider or on-call provider? For example, be connected immediately or receive a call back within 30 minutes?

WHA's After-Hours Access Standards

- Provider Telephone Access - 24 hours a day, 7 days per week
- Appropriate Emergency Instructions - 24 hours a day, 7 days per week
- Telephone Screening &Triage Wait Time - Not to exceed 30 minutes

Provider Telephone Access, Triage & Screening Guidelines

Providers should provide or arrange for the provision of 24/7 telephone access, triage or screening services. The telephone triage or screening services should be provided in a timely manner appropriate to the patient's condition, and the triage or screening wait time should not exceed 30 minutes.

Providers should maintain a procedure for triaging or screening patient's telephone calls, which includes the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

- Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and
- How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

The provider is responsible for the actions of the office staff or answering service:

- If a patient calls after hours or on a weekend for a possible medical emergency, there should be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."
- Office staff/answering services handling patient calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the patient so that the patient can be referred to licensed staff; however, they are not permitted to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the patient, or to determine when a patient needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.
- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a patient that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.
- The answering service as well as office staff should document all calls.

10.5.2. Continuity and Coordination of Medical Care Continuity and Coordination of Medical and Behavioral Health Care

WHA's continuity and coordination of care activities focus on transitions between providers of care and settings of care. Annually WHA collects data regarding the coordination of medical care across the provider network; conducts quantitative, qualitative and barrier analysis, to assist in the identification, prioritization and selection of four opportunities for improvement; implements interventions to improve performance for the opportunities selected and annually measures the effectiveness of improvement activities.

There is a high level of collaboration between WHA and Optum BH, WHA's provider of BH services, for the purpose of coordinating care between medical and BH practitioners. Areas of focus are: the exchange of information between PCPs and BH practitioners; appropriate diagnosis, treatment and referral of BH disorders commonly seen in primary care; the appropriate use of psychopharmacological medications, management of treatment access and follow-up for members with coexisting medical and behavioral disorders; primary or secondary preventive behavioral healthcare program implementation; special needs of members with severe and persistent mental illness; and the development of Clinical Practice Guidelines (CPGs) that address BH conditions. Annually, WHA and Optum BH analyze data to identify at least two (2) opportunities to improve the coordination of general medical care and behavioral healthcare, implement interventions to improve performance for the opportunities selected and measure the effectiveness of the improvement activities. The current focus areas are Antidepressant Medication Management (AMM), and

the Initiation and Engagement of Opioid Abuse or Dependence Treatement (IET).

To assist providers of care in communicating relevant patient information between medical and BH care, WHA has provided additional information on its secured website at Login - www.westernhealth.com.

Optum Behavioral Health has Coordination of Care information on their Provider Express portal at https://public.providerexpress.com/content/ope-provexpr/us/en/about-us/coordination-of-care.html. In addition, behavioral health referrals can be placed directly with Optum Behavioral Health in their online Support and Services Manager (OSSM) at https://ossmportal.optum.com/en/home

10.5.3. Medical Record Documentation and Management

WHA delegates medical record management/health information management and documentation functions to its contracted medical groups/IPAs and has policies/procedures and standards with performance expectations in place. WHA maintains responsibility for oversight of these functions and assesses the delegate's compliance to the standards through policy/procedure review, semi- annual reports submitted by the delegate, annual medical record documentation audits, and onsite visits, when required. See WHA's Medical Record documentation & Management Standards in Appendix 2.

WHA 's medical record documentation policy/procedure addresses the eleven key medical record documentation standards for the ambulatory care setting, the practitioner's expected performance threshold, and the methodology the Plan uses to audit practitioner performance. PCPs with 100 or more assigned WHA members are subject to audit, with 8-30 charts to be reviewed depending on the number of members assigned to the practitioner. Annually one third of the practitioners for each delegated medical group/IPA are subject to audit. A passing audit score is 90%.

WHA's Medical Record documentation & Management Standards in Appendix 2.

10.5.4. Member Rights and Responsibilities

The rights and responsibilities of WHA members are outlined in the "Member Rights and Responsibilities Statement", which is provided to members and practitioners through several media channels including but not limited to the WHA website, the *New Provider Orientation Packet* and the *Member Guidelines Booklet*. A hard copy of the "Member Rights and Responsibilities Statement" can be requested from WHA's Member Services Department by calling (916) 563-2250. Contracted providers/practitioners and members must comply with the requirements set forth in this document.

Member Rights and Responsibilities Statement

WHA's Member Rights and Responsibilities Statement is included as Appendix 3.

10.5.5. Patient Safety

Promotion of safe clinical practices is a component of WHA's QI Program and the QI programs of its contracted medical groups/IPAs. WHA monitors contracted provider safety activities through semi-annual reports the medical groups/IPAs submit to the Plan.

WHA's Patient Safety Goals are adopted from the National Quality Forum and include:

- Reduce harm from inappropriate or unnecessary care.

- Reduce preventable hospital admissions and readmissions.
- Reduce the incidence of healthcare associated conditions.

WHA addresses patient safety through the following mechanisms:

- Providing Member, practitioner and provider education regarding safe clinical practices.
- Communicating of safety related information to members, practitioners and providers through WHA publications, the WHA website, and other media.
- Identification of opportunities to improve safe practices at practitioner offices.
- Monitoring contracted hospital progress toward implementing Leapfrog safe practices, participating in Leapfrog's Never Events Policy and reporting hospital safety data to publicly reported entities as required by Covered California.
- Monitoring contracted hospital performance with The Joint Commission – National Patient Safety Goals (NPSG's) reporting. The Joint Commission determines the highest priority patient safety issues and how to best address them.
- Monitoring contracted hospital performance with CalHospitalCompare.org survey findings related to clinical quality, patient experience and patient safety.
- Monitoring appropriate contracted hospital performance with California Maternal Quality Care Collaborative (CMQCC) metrics on maternity care services.
- Monitoring practitioner practices related to organized documentation, confidentiality and practitioner accessibility of medical records for safe and effective medical communication.
- Monitoring continuity and coordination of care between practitioners and between settings of care to identify issues with miscommunication or lack of communication.
- Providing PCP's education regarding Behavioral Health (BH) conditions commonly seen in a PCP's practice;
- Identifying and timely follow-up on clinical issues raised through Nurse 24 Advice Line, including the use of WHA's Cardiovascular and Diabetes Disease Management programs and Complex Case Management services.
- Monitoring the HEDIS® measures such as Appropriate Treatment for Children with Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults with Bronchitis, Use of Imaging Studies for Low Back Pain and Plan All-Cause Readmissions.
- Additional monitoring of the safe use of pharmaceuticals through WHA's drug recall and drug utilization review processes.
- Monitoring patient safety in the Behavioral Health (BH) environment through analysis of quarterly and annual reports submitted by the BH contracted vendor.
- Monitoring appeals and grievances to identify patient safety issues.
- Investigating all potential quality of care issues by WHA's clinical staff.

10.5.6. Risk Management / Quality Issues Management

Semi-annually, WHA sends member/practitioner specific reports to each contracted medical group/IPA

noting the complaints/grievances the Plan has received. The contracted entities can utilize this information as part of their ongoing monitoring related to practitioner recredentialing. The reports include any practitioner office site quality complaints received by WHA. Any physician who reaches the threshold established for such complaints may be subject to a site visit, conducted by the medical group, within sixty (60) calendar days of reaching the threshold.

Aggregate data on quality issues are reported to the QIC quarterly and potential risk management issues are reported to WHA's Compliance Department. For questions or more information about identifying and reporting PQI activity, please contact WHA's Corporate Quality Director. Please refer to your Clinical Provider Handbook for more details.

10.5.7. Member & Provider Experience

Member Experience

WHA identifies and prioritizes opportunities for improving the member experience. Decisions regarding which opportunities to pursue are based upon a quantitative, qualitative and barrier analysis of the following:

- Annual CAHPS Member Survey results
- Medicare CAHPS Survey Results
- Annual QHP Survey results
- Annual Patient Assessment Survey (PAS)
- Annual analysis of member complaints, grievances and appeals.

WHA's Appeals and Grievances Manager is responsible for reporting member experience information related to complaints, grievances and appeals received by WHA to the QIC on a quarterly basis. The Clinical Quality Manager reports the CAHPS, M-CAHPS, PAS, and QHP member survey results annually to QIC. All of these reports are compiled and presented to the Quality Experience Workgroup annually to identify priority projects and activities to improve our members' experience. In addition, WHA shares the results of QI activities and member satisfaction surveys with its medical groups, vendors, practitioners, and providers, as appropriate. Finally, and most importantly, the outcomes will be presented up to the Board of Directors.

Provider Experience

Providers are required to respond promptly to all regulatory surveys. The Provider experience is monitored at least annually through a Practitioner/Provider Satisfaction Survey. Quality staff and Provider Relations are responsible for the survey, analysis of the results, and for reporting the results to the QIC. Practitioner/provider complaints are also monitored, categorized, and reported to the QIC. Improvement opportunities are identified from these sources.

10.5.8. Pay for Performance (P4P) Program

To obtain standardized clinical quality measure performance, WHA participates in the Integrated Healthcare Association (IHA) sponsored Aligned Measures Program (AMP) collaborative for the majority of its P4P HEDIS measures. P4P measure scores not included in the AMP program are obtained from WHA's annual NCQA Commercial HEDIS report. Patient Experience measures are obtained through WHA's annual NCQA CAHPS survey. Individual measure payout percentage is determined by performance against applicable benchmarks. Total available incentive amount for Commercial is $1.00 per member per month (PMPM) and for Medicare Advantage it is $0.25 PMPM.

Additional information about payment contingencies for the total P4P payout can be provided by your respective medical group.

- Commercial Program Components
  - 65% weight – Clinical Quality
  - 30% weight – Patient Experience
  - 5% weight – SDOH & Health Equity
  - 10% weight – Stretch Bonus

For more detailed information regarding your medical group's priorities and goals related to their participation in the WHA Value Based P4P program, please contact your Provider Relations/Medical Staff office.

10.6. Disclosure

The Quality Improvement ("QI") Program Description and Work Plan are reviewed and approved by WHA's QIC members and are available to WHA Providers. WHA provides information to practitioners and members annually regarding the QI Program and the Plan's progress in meeting goals.

10.7. Conflict of Interest

In no case shall a physician or individual involved in quality assessment and improvement, utilization management, or risk management have direct responsibility for the review of any case (for quality of patient care or appropriate utilization of resources) in which he/she is professionally or personally involved. Even if an otherwise qualified reviewer has identified a potential for conflict of interest, another reviewer shall become involved with the case or activity.

10.8. Non-Discrimination

Providers and Participating Physicians shall not discriminate or differentiate in treatment of any member because of race, color, creed, national origin, health status, ancestry, religion, sex (including gender, gender identity and gender expression), marital status, sexual orientation, physical or mental handicap, age, or any other protected class.

11. Utilization Management (UM)

11.1. Utilization Management Program

WHA has a comprehensive UM Program (UMP) that provides the infrastructure for ensuring that health plan members receive appropriate, quality and cost-effective healthcare services. The UMP incorporates NCQA accreditation standards and is designed to ensure compliance with all the statutory and regulatory requirements of California's DMHC.

WHA's UMP goals are met through the ongoing, systematic monitoring and evaluation of the services provided, evaluation of the appropriateness of care and resources, and oversight of delegated UM activities to ensure compliance with contract requirements and WHA policies. The UMP is designed to ensure that utilization issues are identified, addressed, documented and resolved in a consistent and timely manner. Monitoring and evaluation activities are carried out by UM and QI staff at both the corporate and delegated entity levels.

The UM program ensures that practitioners can freely communicate with their patients about their treatment, including medication treatment options, regardless of the member's benefit coverage. UM decisions are based on the appropriateness of care and service and appropriate coverage. There are

no rewards for issuing a denial and there are no financial incentives that would lead to underutilization.

UMP functions include, but are not limited to the following activities:

- Develop and approve clinical criteria for UM decision making;
- Conduct prospective, concurrent and retrospective review of medical and behavioral health care services;
- Authorize or deny services based on medical necessity;
- Provide communication sources for members/providers seeking UM process clarification;
- Emergency services;
- Appeal management;
- Ensure appropriate providers make UM decisions;
- Ensure consistency in making UM decisions;
- Facilitate the referral process;
- Provide planning and follow-up services;
- Case management, both routine and complex;
- Ensure continuity of care for members;
- Evaluate member and provider satisfaction with UM processes;
- Evaluate new technology;
- Monitor utilization trends including over and underutilization of services; and
- Oversight of delegated activities.

The written Utilization Management Program Description (UMPD) defines the goals, scope, structure, and functional components of the program and the oversight of delegated UM activities. The UM Work Plan is a dynamic calendar that addresses required UM activities, UM QI initiatives and planned oversight activities. Annually the UMPD and the UM Work Plan are reviewed/approved by the Utilization Management Committee (UMC) and the QIC and are subsequently submitted to WHA's Board of Directors for approval.

WHA's UM policies and procedures, which are updated annually and as necessary, provide the details for each UM oversight function or component of the UMP. These documents can be accessed on WHA's website at westernhealth.com in the Provider's Utilization Management system.

11.1.1. Authority, Accountability, Responsibility

WHA's Board of Directors has ultimate authority, accountability, and responsibility for WHA's UM Program and has delegated the day-to-day operations of the program to WHA's CMO/Medical Director, with oversight by the UMC, a subcommittee of the QIC. UMP information flows to and from the Board of Directors through the CMO/Medical Director and quarterly reports from the QIC.

11.1.2. Program Scope

The UM Program applies to all network providers who offer services to WHA members and who make UM decisions affecting those members.

The UMP's scope includes, but is not limited to, monitoring and evaluating the services provided in

inpatient/acute care hospitals, home care, skilled nursing facilities, sub-acute facilities and ambulatory settings. UM Program staff also work to coordinate care for WHA members hospitalized outside the service area.

11.1.3. Utilization Management Committee (UMC)

WHA's UMC is a staff and practitioner based Committee chaired by WHA's CMO, which meets monthly at least ten (10) times per year. The UMC is a subcommittee of the QIC. UMC membership is multidisciplinary and consists of a team of primary and specialty care physicians, a behavioral health physician, WHA's CMO, WHA's Assistant Medical Directors, WHA's Pharmacy Director, WHA's Corporate Quality Director and representatives from WHA's Utilization, Quality and Population Health Management, Appeals and Grievances and Member Services Departments. UM leaders from contracted medical groups attend meetings as able and collaborate informally with WHA on a frequent basis.

11.2. UM Delegation Arrangements

For the most part, WHA delegates UM functions to its CMGs/IPAs and the Plan's chiropractic/acupuncture, dental, and Behavioral Health (BH) carve-out organizations. Out of Area urgent/ER services and emergency admissions, non-network second opinions, organ/bone marrow/stem cell transplants, cancer clinical trials, continuity of care, gender-confirming surgical procedures and experimental/investigational treatment requests are not delegated.

Management of member appeals and grievances is generally also not delegated to WHA's contracted providers *except* for members who receive BH services through WHA's NCQA accredited Managed Behavioral Health Organization (MBHO).

Delegated UM/CM functions and activities may include:

- Prospective, concurrent and retrospective review, both routine and expedited;
- Authorization and denial of services including facility admissions, specialty consultations, outpatient treatment/services and supply requests;
- Case management: routine and complex;
- Coordination of care;
- Discharge planning; and
- Provider appeals (first level).

11.2.1. Behavioral Health Services

WHA delegates all BH UM services, related claims processing, and member grievance and appeals management to Optum Behavioral Health (BH).Members may self-refer for BH services, but may contact Optum BH for assistance in locating a provider by calling (800) 756-6820.

11.2.2. Chiropractic/Acupuncture Services

WHA delegates UM functions and claims payment associated with chiropractic and acupuncture services to Landmark Healthcare. WHA handles any and all related appeals and grievances. WHA members may self-refer for chiropractic and acupuncture services to any Landmark participating provider. Prior authorization is not required. For general information about Landmark's chiropractic and acupuncture services go to their website at www.landmarkhealthcare.com or call Landmark at (800)

638-4557.

11.3. Access to Services / Referrals / Benefit Interpretation

11.3.1. Advantage Referrals

The Advantage Referral Program was developed by WHA to allow members access to any appropriate participating specialist within the Plan's network rather than limiting their choice to a specialist within their PCP's medical group/IPA. All WHA contracted specialists are in the Advantage Referral Program. For example, if a Mercy Medical Group PCP determines that a patient needs to see a specialist, the member may see any WHA network specialist who participates in WHA's network regardless of medical group affiliation.

Advantage Referrals do **not** require prior authorization for the first three (3) visits with a participating specialist. However, for tracking purposes and to facilitate appropriate reimbursement, a referral from the PCP is required except as noted below. The specialist can provide "routine" services, such as ordering lab work and plain x- rays without obtaining permission from the group, but if the specialist recommends "special" tests, procedures, surgery, or additional visits, prior authorization is needed from the member's group/IPA to ensure coverage. If medical necessity is established by the member's group/IPA for continuing care by a specialist, the member may receive additional authorized services from the Advantage Referral specialist beyond the initial three (3) visits if they choose.

OB/GYN services for women and annual dilated eye exams (when covered) are included in the Advantage Referral Program and do **not** require a PCP referral or Prior Authorization..

Advantage Referrals are for care provided by a specialty physician (or clinical provider) practicing within WHA's medical groups/IPA's. Advantage Referral does not include out-of-group referrals for Physical, Speech or Occupational therapies. Advantage Referral specifically excludes tertiary care at UCD, and UCSF.

Billing for Advantage Referral Services

If you are a specialty provider rendering an *Advantage Referral* service to a WHA member who is assigned to a PCP from another group, you should send the bill for services directly to the patient's affiliated group, not the Plan, for reimbursement. Your office staff should be directed to mark the bill as an Advantage Referral service to ensure faster claims processing.

The member's affiliated group is listed on their WHA ID card. The PCP's group affiliation can also be found in the online Provider Directory or through online eligibility verification on WHA's website at westernhealth.com. If there are any billing or claims issue, please contact WHA.

This information can also be confirmed by calling WHA's Member Services Department at (916) 563-2250, Monday through Friday, 8 a.m. to 6 p.m.

For more details on the Advantage Referral Program see WHA's UM policy titled: *"Advantage Referral"* on WHA's website at westernhealth.com in the WHA Group Med Admin pages of the Provider section.

11.3.2. Direct Access Services

WHA members can access the following services without a referral:

- Emergency care

- Urgent care
- Annual eye examinations (when covered)
- Annual gynecological exams
- OB/GYN services
- On-call physician services
- BH/MH services
- Chiropractic and acupuncture (when covered)

11.3.3. Standing Referrals

Members with certain life-threatening, degenerative or disabling conditions or a disease requiring specialized medical care over a prolonged period of time, including HIV or AIDS, may be allowed a *Standing Referral*. A Standing Referral allows the member access to a specialist and/or specialty care services from a provider with expertise in treating the medical condition or disease that requires ongoing monitoring. A Standing Referral will be issued if the member's PCP determines, in consultation with the specialist or specialty care center and the Plan's Medical Director, that the member needs continuing care from a specialist.

The Plan or contracted group may limit the number of visits to the specialist, limit the period of time that the visits are authorized, and require that the specialist provide the PCP with regular reports on the health care provided to the member. A treatment plan describing the course of care/treatment to be provided by the specialist or specialty care center should be agreed upon by the PCP, specialist and Medical Director or designee, with the member's approval.

After the Standing Referral is made, the specialist will be authorized to provide health care services to the member that are within the specialist's area of expertise and training in the same manner as the member's PCP, subject to the terms of the treatment plan.

HIV/AIDS Standing Referrals

Specialists in WHA's provider network with specific expertise treating HIV or AIDS are noted in the Provider Directory. Determinations regarding the need for a member to receive ongoing care from an HIV-AIDS Specialist will be made within three (3) business days of the date the request is received, or within four (4) business days of receiving the proposed treatment plan (if needed). The member, member's PCP, and the HIV-AIDS Specialist will be notified in writing of approval for the standing referral within established decision/notification timeframes and per plan/group UM protocols.

11.3.4. Second Opinions

WHA and its contracted groups must provide second opinions for members at the request of their treating physician, or at the member's request when certain conditions and criteria are met (as defined by regulatory statutes and as deemed appropriate by the group/Plan). Second opinions should be arranged with appropriately qualified health care professionals of like-specialties within WHA's provider network, whenever possible. When an appropriately qualified specialist is not available within WHA's provider network the Plan will review the request for an out-of-network second opinion and will select an appropriate provider.

CMGs/IPAs are financially responsible for in-network second opinions. WHA is responsible for reviewing out-of-network second opinions and paying for those that are approved by the Plan.

Second opinions must be provided in a timely manner appropriate to the urgency of the member's medical

condition. When submitting an out-of-network second opinion request the provider must include pertinent clinical records with its submission to WHA's Clinical Resources Division. Routine decisions must be made within five (5) business days of receipt of the request and all required clinical records. Expedited cases must be completed within 72 hours. WHA's confidential Clinical Resources fax number is (916) 568-0278.

For more detailed information about the second opinion process and requirements, see WHA's UM policy titled: "*Second Opinions"* on WHA's website: westernhealth.com.

11.3.5. Emergency Services

Services necessary to screen and stabilize members who present to an emergency room (ER) must be provided without barriers or the need to obtain prior authorization per California statute. At a minimum, ER screening evaluations for members with a medical and/or BH condition must be paid without question.

CMGs/IPAs are financially responsible for in-network emergency and urgent care services provided within the service area to their assigned members. WHA is financially responsible for emergency and urgent care services for emergency and urgent care services outside the medical group's service area.

Members who have received emergency or urgent care services are directed to receive any post-stabilization continuing or follow-up care from their PCP or another network specialist as appropriate. A member requiring hospitalization at an out-of-area facility will be transferred to an in-network facility when appropriate. WHA's Clinical Resource nurses work in collaboration with the medical groups' UM and case management staff to facilitate timely and appropriate out-of-network hospital transfers.

For details about emergency coverage, see WHA's UM policy titled: "*Emergency- & Urgent Care Services"* on WHA's website: westernhealth.com.

11.3.6. Experimental and New Technology Requests

Experimental requests are for services, devices, drugs, treatment or procedures that are outside the usual and customary standard of practice, have not been FDA approved or have not yet been proven to be efficacious or safe per valid clinical trials. CMGs/IPAs should refer all requests suspected to be experimental in nature to WHA's Clinical Resources Division for review and determination. If deemed experimental after review, denial letters are issued by the Plan with the reason: "Experimental, not a covered benefit", along with appropriate details for individual decisions. If the requested service is determined ***not*** to be experimental, the referral is returned to the requesting provider group for medical necessity determination. Relevant information for experimental review and decision-making should be faxed to WHA's Clinical Resources fax line at (916) 568-0278.

WHA uses Hayes, Inc. to provide *New Technology Assessment* criteria, InformedDNA and/or UpToDate® Decision Support tools to support experimental decisions. For individual cases requiring independent medical review, WHA contracts with IMEDECS. Board-certified clinical specialists from IMEDECS and InformedDNA provide opinions and recommendations based on the treating physician's request, the member's medical condition/circumstances and records, the specialists' expertise, available clinical trials and other current scientific evidence/opinions obtained from reliable medical sources.

WHA may request expert review by InformedDNA for genetic testing requests to determine appropriateness of the test and potential to impact the care provided. If the results of the requested genetic test will not impact the treatment then the request is denied as not medically necessary.

Services, devices, drugs, treatment and procedures determined by WHA to be experimental are not covered benefits for WHA members. However, there are a few rare exceptions where a member may be

allowed experimental service coverage. The following are examples of situations when an experimental service may be approved:

- A regulatory body (DMHC) requires the Plan to provide/cover the service
- The member has undergone every known conventional treatment, and/or
- The member's condition is life-threatening and there is no other alternative.

Information Related to Hayes, Inc. Ratings

Hayes, Inc. uses a rating system (A, B, C, D), along with other information to provide WHA with criteria and recommendations about experimental requests. Procedures and treatments assigned "A" ratings are automatically considered the standard of practice. A "B" rating indicates the treatment was recently determined not to be experimental by the general medical community. "B" ratings are reported quarterly to WHA's UM Committee for discussion and for approval as future covered benefits.

A "C" rating deems the request investigational and/or experimental indicating that data on the procedure is inconclusive regarding safety and/or efficacy. A "D" rating conveys one of two conclusions: either the majority of the medical community does not support its use or the research regarding the procedure, device or drug is so limited that an appraisal of safety and efficacy cannot be made. In rare situations a member may be allowed a service with a Hayes "C or D" rating even though technically it may be considered experimental, and thus is not a covered benefit. WHA's Chief Medical Officer, Medical Director and/or Assistant Medical Director(s) make these decisions based on information gathered during the investigation of the request, and on legal statutes and recommendations provided by Hayes' clinical experts.

For more detailed information about WHA's experimental/new technology processes and requirements and Hayes, Inc. ratings, see WHA's UM policies titled: "*New Technology Case Evaluation* and *New Technology Benefit Assessment"* on WHA's website in the Provider section.

For general information about Hayes, Inc., you can visit their website at www.hayesinc.com.

11.3.7. Benefit Interpretation & Medical Policies

WHA's Clinical Resources Division does not create its own specific medical policies, but maintain a "quick reference guide" called the *Prior Authorization & DME Benefit Matrix to supplement nationally recognized medical necessity criteria such as MCG or InterQual that its delegated medical groups use. The "Benefit Matrix"* is updated at least annually by WHA. The guide is available to the UM staff and managers of WHA's delegated medical groups/IPAs on WHA's website in a secure Provider log-in section under Utilization Management. While this matrix can be a useful tool for UM reviewers, decision makers, claims and Member Services staff, definitive coverage decisions should be based on the most current medical necessity criteria used by the delegated entity, and on the individual contract or member's benefit package. To ensure accuracy of coverage decisions, refer to the member's specific Evidence of Coverage/Disclosure Form (EOC/DF) and the corresponding Co-payment Summary. The current *Prior Authorization and DME Benefit Matrix,* EOC/DF and Co-payment Summaries are all available on WHA's website at westernhealth.com. EOC/DF information for individual members are available in the Eligibility verification section of the website.

If you are unable to make a coverage determination based on these Plan documents, you may request individual benefit interpretation through WHA's Clinical Resources Division. Requests for benefit interpretations can be faxed to Clinical Resources confidential fax at (916) 568-0278. To obtain a request by

phone call Member Services at (916) 563-2250 or (888) 563-2250 and ask to speak to a Clinical Resources nurse.

11.4. Authorization Decisions

Most prior authorization, concurrent and retrospective review decisions are made at the contracted medical group/IPA level since UM and claims functions have been delegated to these entities. There are, however, situations in which WHA's Clinical Resources nurses, Chief Medical Officer, Assistant Medical Directors, and Clinical Pharmacists make authorization decisions for certain services, especially those for which the Plan has financial risk. In general, WHA is responsible for reviewing the following requests at the Plan level regardless of which entity has financial risk:

- Transplants (all types)
- Out-of-network *second opinion* consultations
- Out-of-area emergency, urgent care, and hospital admissions
- Experimental/new technology requests
- Cancer Clinical Trials
- Requests for Continuity of Care for new enrollees and those with terminating WHA providers
- Gender-Confirming Surgical Procedures and related services
- Pharmacy benefit – Prescription drug authorizations
- Other group contract-specific reviews (varies)

Authorization reviews include screening of all available pertinent clinical and other relevant information against the member's covered benefits and established medical necessity criteria, while using the reviewer's clinical expertise to make objective and consistent decisions. Information needed to make informed review decisions may require additional medical record documents or direct consultation with the member's treating practitioner. Groups referring cases to the Plan for reviews/decisions are expected to provide adequate/appropriate medical records and documentation to support the requested service for each case.

When medical necessity criteria are not met, first-line UM reviewers (usually nurses) must refer the case to their Medical Director(s) or to another appropriately designated medical or mental health care professional or review body for final decision-making. Nurse reviewers cannot deny or modify requests that require medical necessity

decisions or questionable clinical benefit assessments. Whether an authorization decision is made by the Plan or at the CMG/IPA level, each reviewer must follow the same basic review principles and adhere to written policies to ensure compliance with regulatory and contractual requirements concerning turnaround times and written notifications of decisions.

Retrospective review of claims for services already rendered that involve medical necessity decisions must also be performed by qualified clinical staff at both the Plan and medical group/IPA levels (depending on delegation status). The same process and screening criteria used for other medical necessity decisions is required for retrospective reviews, except for the timeframes required for completion and notification. Claims and other cases where first-line UM reviewers cannot establish medical necessity through use of established criteria must be forwarded to a qualified practitioner or review committee for retrospective decision-making.

For more details regarding WHA's authorization processes, see WHA's UM policies titled: "*Prospective*

Review", "Concurrent Review", and *"Retrospective Review"* on WHA's website: westernhealth.com.

11.4.1. Medical Necessity Criteria

Medical necessity decisions must be supported by relevant clinical data appropriate for each case. WHA has approved the following criteria when making medical necessity decisions: InterQual/McKesson Treatment Guidelines, MCG® (formerly Milliman Care Guidelines®), UpToDate® and Hayes, Inc. *New Technology Assessment and Experimental Treatment Guidelines*. Medicare Coverage Benefits may also be considered. Medical necessity criteria must be reviewed and approved annually by the delegate's appropriate committee(s) and by WHA's UM Committee (UMC), which consists of actively practicing physicians and other practitioners with relevant health care expertise.

In addition to the above resources, CMGs/IPAs may also develop and use their own internal guidelines/criteria as long as they meet federal and state regulatory requirements and current NCQA standards. WHA and its delegated groups must use appropriate professionals along with approved criteria when making medical necessity decisions. Requirements related to appropriate professionals include use of:

- Appropriately licensed health professionals to supervise all review decisions;
- Appropriate practitioners to make any denial/modification of care decisions;
- Licensed medical physicians to review any denial/modification decision based on medical necessity;
- Psychiatrists, doctoral level clinical psychologists, or certified additional medical specialists to review any denial of BH that is based on medical necessity; and
- Board-certified consultants with appropriate specialty expertise to assist in making medical necessity decisions as needed.

For additional information related to medical necessity criteria, see WHA's UM policy titled: "*Clinical Criteria-UM Decisions"* on WHA's website: westernhealth.com.

11.4.2. Inter-Rater Reliability Testing

Clinical reviewers (doctors and nurses) at WHA and at the contracted medical groups/IPAs who make authorization decisions must participate in routine inter-rater reliability (IRR) testing. IRR testing must be conducted upon hire and at least annually thereafter to ensure consistency of decision-making among peer reviewers. More frequent internal audits may be performed at the discretion of WHA or the group/IPA to ensure ongoing consistency and appropriateness of decision-making. WHA conducts annual delegation oversight audits and ensures that appropriate improvement interventions were undertaken by the delegated entities when indicated. Additionally, WHA conducts IRR testing of its own nurse and physician reviewers (CMO and Assistant Medical Directors), pharmacists and pharmacy techs on at least an annual basis. Periodic review of denial tracking logs, appeal findings, and denial letters issued by contracted groups/IPAs also provide WHA with current information about the consistency of UM decisions made by its delegated entities. For more details, see WHA's UM policy titled: "*Inter-rater Reliability"* on WHA's website: westernhealth.com.

11.5. UM Denial Process

Initial review decisions made by WHA or a CMG/IPA must be communicated and documented within twenty-four (24) hours to the requesting provider. This is followed by written notification within two (2)

business days of the decision to all involved parties, including the member and requesting practitioner, in compliance with DMHC notification policies. Denial letters must state the reason for the adverse decision in clear, concise and easily understood language; cite the specific criteria used to support the decision; provide the name, title and contact information for the physician reviewer that made the medical necessity decision and must be signed by the physician, psychiatrist, pharmacist or other qualified professional who made the decision.

All decision letters must provide state-mandated language regarding the members' appeal rights, including an explanation of how to request an expedited (fast track) appeal and how and when to file a grievance with WHA or an outside agency, such as the DMHC. WHA's denial letters are updated as needed to ensure ongoing inclusion of all required regulatory language. Updated denial letter templates are available for download to delegated groups/IPAs in the library section of the HICE website under "Approved ICE Documents" at www.iceforhealth.com.

A description and examples/excerpts of the medical necessity criteria used by WHA and its delegates for review decisions must be provided to physicians, members and the general public upon request. When a service request is denied as a non-covered benefit, appropriate benefit exclusion language from the member's *Evidence of Coverage/Disclosure Form* (EOC/DF) booklet must be cited. Member-specific EOCs are available for review staff on WHA's website in the member eligibility screens.

If a request for a service is denied because benefits are exhausted or are not included in the member's benefit package, UM/CM staff should attempt to assist the member with transitioning care/services to another provider, or by offering an alternative source within the network or through community resources to ensure continuity of care. A statement offering alternatives must be included in all denial notification letters.

For more details about WHA's denial process, see WHA's UM policies titled: "*Denial Process"* and "*Denials-Delegation Oversight"* on WHA's website: westernhealth.com.

11.6. UM Decision Timelines

WHA and its contracted medical groups/IPAs must adhere to regulatory and accreditation turnaround timeliness (TAT) standards when completing reviews, making coverage decisions and issuing notification letters. Required timeframes for making UM decisions are as follows:

Precertification of Non-urgent Care

- Decisions to be made within five (5) business days of receiving the request and necessary medical information (WHA's preferred TAT Goal: two (2) days).
- Practitioner to be notified of decision within 24 hours of decision (phone, fax, or electronic)
- Decisions must be provided in writing to member and requesting Practitioner within two (2) business days of decision.

Precertification of Urgent Care (Expedited request)

- Decision and initial notification to Practitioner and member must be made within one (1) calendar day.
- Member and Practitioner must be notified at the time of the denial how they can initiate an expedited appeal.

- Member and Practitioner must be given written confirmation of decision within two (2) business days of decision.

Concurrent Review

- Decisions for inpatient, intensive outpatient and residential BH care are to be made within 1 business day of obtaining necessary information.
- Decisions for ongoing ambulatory care are to be made within ten (10) business days of obtaining all necessary information.
- Practitioner to be notified of decisions within one (1) business day of decision.
- If review results in a denial, both member and Practitioner must be provided written confirmation within one (1) business day of original notification and be informed how to initiate an expedited appeal at time of notification.

Retrospective Review

- Decision to be made within thirty (30) business days of obtaining necessary information.
- Practitioner and member to be notified in writing of denial within five (5) business days of making decision.

Prescription Drugs

- Urgent or exigent circumstances– Decision and notification of provider and member to be made within twenty-four (24) hours of receipt of the request
- Non-urgent - Decision and notification of the provider and member to be made within seventy-two (72) hours of receipt of the request.
- *Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function OR when an insured is undergoing a current course of treatment using a non-formulary drug.

For details about notification timeframe requirements, see WHA's UM policy titled: "*Timeliness of UM Decisions"* on WHA's website: westernhealth.com. See also current versions of "UM Turn-Around Time Tables" for the commercial line of business on the HICE web site: www.iceforhealth.com.

11.7. UM Communication Services

WHA's clinical staff at the Plan level is available to practitioners and their office staff during regular business hours Monday through Friday, 8 a.m.- 5 p.m. by calling WHA Member Services at (916) 563-2250 or (888) 563- 2250 or TTY/TDD 711 and asking to speak with a Clinical Resources representative. If making a call during business hours, select Option 5, then in the Provider Menu, press 6 or to leave a message for WHA's clinical staff about a UM inquiry after hours, select Option 5. The message service is available 24 hours a day/7days a week. All messages left after hours will be answered with a return call the next business day. Inquiries may also be faxed directly to WHA's Clinical Resources Division at (916) 568-0278.

If a network physician wishes to check on the status of a case or discuss a Plan-level UM review decision he/she may speak directly with WHA's Chief Medical Officer or Assistant Medical Director

during regular business hours Monday through Friday, 8 a.m. – 5 p.m. by calling (916) 563-2274. If a confidential voice message is left, a return call will be made by the next business day.

11.8. Appeals

11.8.1. Member Appeals

WHA manages all member appeals with the exception of member behavioral health appeals that are delegated to U.S. Behavioral Health Plan, California/Optum Behavioral Health

Members may request an appeal verbally, electronically or in writing, however they are encouraged to send their request in writing when possible. All denial/modification decisions are subject to re-review/reconsideration through WHA's internal member appeal process. The appeal process must be completed within thirty (30) calendar days of receipt of the appeal. Appeals meeting *expedited* criteria must be completed within seventy- two (72) hours of receipt or sooner, depending on the individual circumstances, medical condition and needs of the patient. Expedited appeals may be requested at both the health Plan level and DMHC simultaneously if indicated, and covered services must continue to be provided to a member until the appeal decision is made.

WHA's Member Appeal policies and procedures specify the timeframes for issuing initial notification letters to acknowledge receipt of an appeal, describe timeframes for completing routine and expedited (fast track) appeal requests, and provide information about sending extension notification and resolution letters. WHA has a dedicated department in Medical Management to handle member appeals, which is called the Appeals and Grievances Department. When a member calls WHA's main phone number at 916-563-2250 or 888-563-2250 (toll free) and tells a Member Service Representative they want to request an appeal or file a grievance, intake is performed and the information is forwarded to the Appeals and Grievances specialty unit for processing. If the member chooses to send their request in writing, they submit via the following methods:

Western Health Advantage
ATT: Appeals and Grievances
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Fax: 916-563-2207 | Email: appeal.grievance@westernhealth.com
Website: https://www.westernhealth.com/legal/grievance-form/

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-563-2250, TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

For specific information about the appeal process, see WHA's UM policies titled: "*Appeals Management – Member Standard"* and/or *"Expedited Appeals"* on WHA's website: westernhealth.com.

11.8.2. Provider Appeals (Medical Necessity or UM Denials)

Most provider appeals are handled at the contracted medical group/IPA level, but they may be forwarded to WHA for second level review and decision-making, when appropriate. If the issue involves a medical necessity or other UM decision, the provider appeal can be made directly to the Plan bypassing the contracted medical group/IPA's internal appeal process.

Provider appeals must be submitted to the Plan within sixty (60) business days of receiving the written determination. All provider appeals submitted after sixty (60) business days will be rejected by WHA.

For information regarding provider appeals that involve a claims issue see section 9.5 of this document.

11.9. Care Management

11.9.1. Discharge Planning

Delegated medical group/IPA UM and/or Case Management staff conduct concurrent review and provide discharge planning services for patients who are hospitalized or institutionalized in a network facility and for patients who were prior authorized by the medical group/IPA for admission to a non-network facility (e.g., non- emergencies).

WHA's Clinical Resource nurses follow inpatient stays for WHA members admitted emergently through the ER to out of area acute care facilities and assist medical group/IPA staff to repatriate these patients into a network hospital when appropriate. Once the patient's medical condition is stabilized, facilitating the actual transfer is primarily the responsibility of the contracted group, but WHA is responsible for notifying the group of the need for the transfer and for authorizing medical transport to the in-network facility. UM/CM nurses work in a coordinated effort to ensure timely and appropriate transfers to in-network facilities, to a lower level of care, or discharged home with necessary equipment and home health assistance when indicated.

For more details about the out-of-area hospital transfer process and group/plan risks and responsibilities, see WHA's UM policy titled: "*Out-of-Area Emergency (ER) Admissions"* on WHA's website: westernhealth.com.

11.9.2. Coordination, Continuity and Transition of Care

WHA ensures that new members that fall into the categories listed below are allowed, *upon request, and when appropriate*, to continue receiving limited uninterrupted care from their current non-participating provider for a specified length of time or until a safe transition can be affected to a WHA network provider, as determined by legal requirements and the condition of the patient, including:

- Acute condition: for the duration of the acute condition;
- Serious chronic condition: for a period of time necessary to complete a course of treatment and to arrange for safe transfer to another provider, not to exceed twelve months from the members effective date of coverage;
- Pregnancy: for the duration of the pregnancy and the immediate postpartum period;
- Terminal illness: for the duration of the terminal illness that may exceed twelve months

from the date of the members effective date of coverage;

- Care of a newborn child (age birth to 36 months): for a period not to exceed twelve months from the date of the members effective date of coverage; and
- Performance of surgery or other procedure that has been authorized by WHA as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the member's effective date of coverage.

WHA also ensures that a member with an above-stated condition receiving active treatment from a provider whose contract is terminated, is allowed**,** *upon request and when appropriate*, to continue receiving ongoing care and treatment from that provider for a specified amount of time, or until it is considered reasonably safe to transition the member's care to another appropriate Participating Provider, depending on relevant legal requirements and the patient's diagnosis and treatment plan. This option is not available for a WHA network provider who has been terminated for medical disciplinary cause or criminal activity.

In most circumstances WHA's general practice is to accept continuity of care requests received within thirty (30) days of a new member's effective date of enrollment with the Plan. If a contracted medical group/IPA receives a retrospective request for continuity of care from a new member after services were rendered by a non- participating provider (beyond the thirty (30) day eligibility timeframe), or receives a bill for those services, the group is responsible for making the determination regarding financial responsibility. Continuity of Care requests received more than thirty (30) days from the Effective Date of member's coverage or from the date the provider's terminated with WHA will be evaluated by WHA's Medical Director or group.

WHA makes initial Continuity of Care (CoC) determinations and pays for approved CoC services provided by non-network specialists. CoC authorization decisions are forwarded in writing to the affected medical groups for case management purposes. Once the group is notified, it is responsible for determining when the member's condition/treatment is stable enough to safely transition to an in-network provider. When a member's CoC coverage ends, WHA or its delegated entity must provide information regarding alternatives for continuing care (e.g., transitioning patient's care to in-network specialist who can provide equivalent services as the non-network provider). If the member needs continuing care by the non-network specialist after the initial Plan level CoC authorization expires, the group should forward the request for continuing CoC services to the Plan for decision- making and notifications to all affected parties.

For more details please see WHA's policy titled: "*Continuity of Care"* on WHA's website: westernhealth.com. A C*ontinuity of Care Request Form* is also available on WHA's website and in the Appendix 4 of this document.

11.10. Monitoring and Measuring UM Effectiveness

WHA and its delegates must monitor utilization of services and health care resources to identify potential or actual over or under utilization. Delegates must report UM data to WHA's UMC on a semi- annual basis using established indicators and benchmarks. Data is generated primarily through the collection and analysis of claims and encounter data. Capitated groups must provide utilization data relative to the following indicators semi- annually (as applicable):

- Inpatient Days per Thousand (Medical/Surgical, Behavioral Health);
- Inpatient Admit Rates;
- Average Length of Stay;

- Outpatient Surgery Days per Thousand;
- Outpatient Behavioral Health;
- Outpatient Alcohol/Drug;
- ER Days Per Thousand;
- Skilled Nursing Days per Thousand;
- Readmissions;
- HEDIS indicators;
- Referral Rates;
- Denial Rates;
- Case Management activity;
- Timeliness of Authorizations/Denial and office administered prescription medication decisions.

12. Compliance

It is WHA's policy to demonstrate high ethical standards in our business practices. WHA maintains a comprehensive Compliance Program to prevent, detect, and correct violations of Compliance Authority and to improve overall compliance.

12.1. Privacy, Security and Confidentiality

Western Health Advantage (WHA) must comply with the Health Insurance Portability and Accountability Act (HIPAA), California's Confidentiality of Medical Information Act (CMIA) and other applicable federal and state laws. WHA's contracted Medical Groups/IPAs must also comply with the same requirements.

To understand what rights your patient(s) have, please visit the link provided. WHA's Notice of Privacy Practices and Privacy Rights Forms are located online at westernhealth.com/legal/privacy

Access, Use and Disclosure of PHI

Protected Health Information (PHI) may only be accessed, used or disclosed as required or permitted by the HIPAA Privacy Rule. If PHI is to be accessed, used or disclosed for other purposes, the member's authorization is required.

WHA's contracted Medical Groups/IPAs must make reasonable efforts to limit the access, use or disclosure of PHI to the minimum necessary to accomplish the intended purpose.

As a Business Associate (BA) and a Covered Entity under HIPAA, Medical Groups/IPAs must:

- Develop and implement written policies and procedures consistent with HIPAA and other applicable federal and state laws;
- Train their workforce on its Privacy and Information Security policies and when appropriate sanction workforce members who violate them;
- Mitigate any harmful effect caused by the impermissible access use or disclosure of PHI; and.
- Adhere to the Business Associate Agreement (BAA) executed with WHA.

The HIPAA Security Rule requires Covered Entities and Business Associates to implement administrative, physical, and technical safeguards to secure electronic PHI (ePHI). Providers are obligated to:

- Ensure the confidentiality, integrity, and availability of all ePHI it creates, receives, maintains, or transmits on WHA's behalf,

- Protect against reasonably anticipated threats or hazards to the security or integrity of the information,
- Protect against reasonably anticipated impermissible uses or disclosures; and
- Ensure compliance by its workforce.

Incident and Breach Reporting

Pursuant to the HIPAA Breach Notification Rule, the California Information Practices Act of 1977 and the BAA with WHA, the BA responsibilities include, but are not limited to:

- Timely notification of an impermissible use or disclosure under the Privacy and Security Rule to WHA, as outlined in the BAA. Impermissible access, use or disclosure is presumed to be a breach unless it can be demonstrated that there is a low probability that PHI has been compromised, based on a risk assessment of at least the following factors:

  (a) the nature and extent of the PHI involved, including types of identifiers and likelihood of re-identification;

  (b) the unauthorized person who used the PHI or to whom the disclosure was made;

  (c) whether the PHI was actually acquired or viewed; and

  (d) the extent to which the risk to the PHI has been mitigated.

- The notification to WHA must be made without unreasonable delay after discovery in accordance with the BAA.
- The notification must include: (a) the identity of each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired, used or disclosed during the breach; (b) all other information that WHA may require in order to make timely and appropriate notifications to affected individuals.
- Business Associates must impose the same regulatory and contractual restrictions and obligations on their business associate subcontractors.

To report incidents or breaches to WHA, send an email to privacy@westernhealth.com. To report information security incidents, send an email to informationsecurity@westernhealth.com. If the notification includes PHI, the information must be sent securely. If a password protected file is sent the password must be provided verbally; it cannot be emailed.

The obligation of a contracted Medical Group/IPA to report a potential breach to WHA is limited to a breach involving PHI created, received, used or disclosed by the Medical Group/IPA on WHA's behalf.

12.2. Fraud and Abuse

Health care fraud is an intentional misrepresentation of facts made to obtain health care benefits, payment, services and other things of value. Health care abuse involves a questionable practice that is inconsistent with accepted medical or business policies. Although it is not an intentional misrepresentation, health care abuse may result in unnecessary costs.

WHA's CMGs/IPAs are expected to develop an anti-fraud program, which should include the following components:

- Implementing fraud prevention activities and communicating such program and activities to staff, contractors and subcontractors.

- Training staff, employed physicians, contracting physicians, contracting pharmacies and other affiliated or ancillary providers and vendors on fraud prevention activities at least annually.
- Communicating awareness, including identification of fraud schemes, detection methods and monitoring activities, to contracted and subcontracted entities.
- Notifying WHA of suspected fraudulent behavior.
- Taking action against suspected or confirmed fraud, including referring such instances to law enforcement and reporting the activity to WHA.
- Cooperating with WHA's fraud detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with WHA in fraud investigations to the extent permitted by law.

Other recommended activities include:

- Applying appropriate claims edits to assure a basic level of appropriateness of claim payment;
- Internal monitoring and auditing,
- Utilizing commercially available software to identify patterns that may be indicative of fraud or abuse; and
- Encouraging employee direct reporting of suspected fraud, waste and abuse,
- Attending commercially available fraud prevention and detection training and seminars.

12.2.1. False Claims Laws

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, as amended, states that those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of a minimum of $13,5085 per false claim assessed after January 30, 2023 (28 CFR 85.3(a)(9).

Under Administrative Remedies for False Claims and Statements, any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and an assessment of not more than twice the amount of the claim.

The Criminal Penalties for Acts Involving Federal Health Care Programs provides for felony criminal penalties and a fine of not more than $100,000 and/or imprisonment for not more than ten (10) years or both for whomever makes false statements or submits false claims.

The California False Claims Act, California Government Code §§ 12650-12655, as amended, applies to fraud involving state, city, county or other local government funds. Violators may be liable to the state or the political subdivision (city, county or other local government) for three times the amount of damages that the state or local government sustains because of the false claims violations, the costs of a civil suit for recovery of damages and a civil penalty of up to $11,000 for each false claim.

12.2.2. Whistleblower Protections

Federal and State *qui tam* or "whistleblower" laws protect against the fraudulent use of public funds by encouraging people with knowledge of fraud against government to blow the whistle on the wrongdoers. The laws provide for whistleblowers to receive a reward in the form of a share of the recovery. The False Claims Act Whistleblower Employee Protection Act prohibits an employer from discharging, demoting, suspending, threatening, harassing or discriminating against any employee, vendor or agent if the individual

reports or assists in the investigation of a false claim.

12.2.3. You Suspect Fraud

Any contractor, agent, vendor, member or WHA representative who is aware of or suspects any false report or document, false claim, improper billing practices, or violations of company policies and procedures, must report their concerns to the WHA Compliance and Ethics Hotline or Compliance and Ethics Department. The WHA Compliance Hotline may be accessed through the website at www.lighthouse-services.com/westernhealth or by calling toll-free (833) 310-0007. Reports may also be submitted through WHA's main phone number at (916) 563- 2250 or (888) 563-2250. Reporters should provide as much detail as possible so that WHA can investigate the issue. Information can also be sent via mail to the attention of the Compliance and Ethics Department at 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833. All information will be kept confidential to the extent possible. An email report can also be made to compliance@westernhealth.com; however, anonymity cannot be guaranteed when sending information through an identifiable email address.

Western Health Advantage will:

- Review and investigate all allegations of fraud and/or abuse, whether internal or external;
- Take corrective actions for any supported allegations after a thorough investigation; and
- Report confirmed misconduct to the appropriate parties and/or agencies, including law enforcement.

13. Delegation Oversight

13.1. Regulatory Compliance

The policy of Western Health Advantage (WHA) is to conduct all business in a professional ethical manner, with adherence to and compliance with the State and Federal laws and regulations that govern the Plan. WHA expects the same level of professional and ethical integrity from its providers and business partners.

13.2. Delegated Claims Payment

All entities delegated for claims payment are required to comply with State and Federal laws and regulations. Such requirements include but are not limited to:

- Timeliness and accuracy of claim payments;
- Automatic inclusion of interest and penalties, when required;
- Timeliness of claim denials;
- Appropriate fee schedule for non-participating providers;
- No demonstrable and unjust or unfair payment pattern;
- Quarterly reporting to WHA, utilizing forms developed by the Health Industry Collaboration Effort (HICE), available at www.iceforhealth.com, and any other forms requested by WHA in order for WHA to fulfill its reporting requirements to the DMHC;
- Compliant handling of PDRs; and
- All other requirements set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations, as amended, and associated statutes.

WHA audits each delegated claims payer to determine compliance. Claims payers that do not meet the WHA standards may be placed on corrective action plans, subjected to additional audits or may be required to take other actions deemed appropriate by WHA to ensure proper claims payment.

13.3. Delegation Oversight of Utilization Management (UM) & Case Management (CM)

As previously stated, WHA delegates UM and CM/CCM functions to contracted medical groups/IPAs that have the capacity to meet WHA's UM/CM/CCM standards as shown through a pre-delegation due diligence assessment. Annual oversight audits, including policy/procedure review and file audits are conducted to ensure continuing compliance with WHA's performance standards, regulatory requirements, and NCQA accreditation standards. A written and signed Delegation Agreement delineates specific responsibilities for WHA and the delegated entity. Delegated entities are required to provide certain documents and reports to the Plan in a timely manner, and cooperate with the oversight responsibilities and audit functions of the Plan as specified in the Delegation Agreement.

Delegated UM/CM functions include, but are not limited to:

- Prospective, concurrent and retrospective review, both routine and expedited
- Physician advisor/peer review (authorizations/denials)
- Case management
- Complex case management
- Discharge planning
- Provider appeals (first level)

For more information about delegation and plan oversight requirements and interventions, see WHA's UM policy titled: "*Delegation Oversight"* on WHA's website: westernhealth.com.

13.4. Delegated Credentialing/Recredentialing

Delegates that carryout credentialing/recredentialing functions must undergo an annual oversight audit, policy/procedure review, and file audits to ensure their continued ability to meet compliance to WHA performance standards, regulatory requirements, and NCQA accreditation standards. Written and signed Delegation Agreements delineate specific responsibilities for WHA and the delegated entity.

Delegated credentialing functions include but are not limited to:

- Initial credentialing and subsequent recredentialing of their providers;
- Conduct monitoring, at least annually, of credentialing system controls;
- Approval of physicians, licensed professionals and organizational providers;
- Reporting deficiencies to the NPDB and State Medical Board;
- Conducting ongoing monitoring activities between recredentialing cycles;
- Conducting practitioner office site quality audits, as indicated;
- Submitting required reports to WHA; and
- Notifying members when a physician is terminated or leaves the Group.

13.5. Delegated Medical Record Management and Documentation

WHA delegates medical record management/health information management and documentation functions to its contracted medical groups/IPAs and has policies and procedures, standards and performance expectations in place for the delegated functions. WHA maintains responsibility for oversight of these functions and assesses the delegate's compliance to the standards through policy/procedure review, annual reports submitted by the delegate, annual documentation audits, and onsite visits when required.

13.6. Financial Viability

WHA has established and implemented a process to monitor the financial viability of CMGs and hospitals. This is done to ensure that CMGs and hospitals are financially solvent and have the ability to pay claims for which they are responsible.

The process includes the review of financial information for both CMGs and hospitals. CMGs, unless they have obtained a waiver from the DMHC, are required to provide WHA with a copy of the quarterly and annual financial surveys submitted to the DMHC under the SB 260 regulations. Hospitals (and CMGs that have obtained a waiver from the DMHC) are required to submit to WHA annual financial statements, prepared in accordance with Generally Accepted Accounting Principles, unless WHA has deemed it necessary to review more frequently, e.g., quarterly or monthly).

WHA's assessment of a CMG or hospital's financial viability is based on the following criteria:

1. Positive working capital
2. Current ratio must exceed 90%
3. Quick ratio and ratio of liquid assets to current payables must exceed .50
4. The minimum cash to claims ratio shall be .75
5. Positive Debt to Equity ratio
6. Positive Tangible Net Equity
7. IBNR claims liability must at least be equal to the minimum equivalent of 2.5 – 3.0 months of average claims liability
8. Administrative costs must not exceed 15%
9. Profit margins and Medical Cost Ratios are evaluated for the industry being reviewed.

A deficiency in any of the above measures will result in the following actions:

CMGs subject to SB 260 are required to submit a corrective action plan (CAP) to the DMHC. A copy of this proposal must be submitted to WHA. Hospitals and CMGs not subject to SB 260 may be required to submit financial reports more frequently; report in greater detail; and/or submit a CAP to WHA as described below. Continued financial deficiency can result in other actions set forth in the contract between WHA and a CMG or hospital.

14. Frequently Used Terms

Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs.
Appeal	Any of the procedures that deal with the review of adverse initial decisions made by the Plan or CMG regarding health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by WHA physicians or review by an independent outside organization as appropriate.
Cultural and Linguistic (C&L)	Communication and services provided to members in a manner that respects those members' cultural and linguistic needs and preferences, within the context of relevant accreditation and regulatory requirements.
Clean Claim	A claim that may be processed without obtaining additional data from the provider of service or from a third party but does not include claims under investigation for fraud and abuse or claims under review for medical necessity.
Centers for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services, the federal agency that regulates the fee-for-service Medicare program, QHPs and Medicare managed care plans.
Concurrent Review	The assessment of medical necessity or appropriateness of services as they are being rendered.
Continuity of Care (CoC)	Ensuring that care is delivered seamlessly across a multitude of delivery sites and transitions throughout the course of the disease
Contracted Medical Group (CMG)/Independent Practice Association (IPA)	A group of physicians or a hospital that has entered into a written agreement with WHA to provide or arrange for the provision of medical services and to whom the Plan has delegated certain responsibilities such as medical management, credentialing, medical records and claims. (May also be referred to as the "delegated group" or "delegated entity".)
Covered California	Covered California™ is the state marketplace established under the Patient Protection and Affordable Care Act that connects Californians to accessible, quality health coverage. For more information, visit www.coveredca.com.
Department of Managed Health Care (DMHC)	The state agency that regulates managed care plans in California.

Emergency Medical Condition	A medical condition, including a Mental Disorder or Condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: • Serious danger to the health of the individual, or, in the case of a pregnant woman, the health of the woman or her unborn child; or • Serious damage to bodily functions; or • Serious dysfunction of any bodily organ or part.
Psychiatric Emergency Services and Care	Psychiatric emergency services and care also pertain to: • Psychiatric screening, examination, evaluation and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and • privileges; and • Care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.
Expedited Appeal	A request for initial determination or appeal is granted an expedited appeal (fast, completed within 72 hours) when failure to receive the requested services could seriously jeopardize the member's health or ability to regain maximum function. This includes conditions such as pain, potential loss of life, limb or major bodily function, a serious life threatening or debilitating condition, or a request for experimental services for a terminally ill member with less than six (6) months to live.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Grievance	Any written or oral expression of dissatisfaction, including any complaint, dispute and request for reconsideration or appeal made by a member, the member's representative or provider, about their experience with WHA, a medical group and/or any WHA participating provider.
High Deductible (HD) Hospital Plan	High Deductible Plan in which only hospital services apply to the deductible (i.e. facility inpatient services, facility ER services or facility outpatient surgery).
HD Health Plan	High Deductible Health Plan
Health Savings Account (HSA)-Qualified HD Plan	A high deductible plan designed to be compatible with a health savings account in which all services apply to the deductible (with the exception of noted preventive care and as otherwise required by law).

Independent Medical Review (IMR)	An external review process for cases where a denial for service(s) or payment for service(s) involving a medical necessity decision or experimental/investigational treatment was upheld by the Plan.
Member	A subscriber or eligible dependent who is entitled to receive covered services
National Committee for Quality Assurance (NCQA)	An independent, nonprofit organization that assesses and reports on the quality of care delivered by managed care organizations.
Non-participating Provider	A physician, facility or other health care provider who is not contracted or a part of WHA's participating provider network. (May also be referred to as "non-contracted".)
Provider	A professional person, organization, health facility, or other person or institution that delivers or furnishes health care services (HSC §1345(i))
Over Utilization	Provision of services that were clearly not indicated or provision of necessary services in either excessive amounts or in a higher-level setting than required.
Participating Provider	A participating physician, participating hospital or other licensed health professional or licensed health facility who, or which, at the time care is provided to a member, has a contract in effect with WHA to provide covered services to members. (May also be referred to as a "contracted provider".)
Plan/Health Plan	Western Health Advantage (WHA)
Potential Quality Issue (PQI)	Any member/provider issue that raises a concern around quality of care, quality of service, a billing or financial issue or system problem that impacts quality of care or service, or an issue affecting a member's ability to access care in a timely manner that resulted in, or had the potential to result in, delayed diagnosis or treatment, temporary or permanent harm to the member, or failure to meet expected legal, regulatory or community standards.
Primary Care Provider (PCP)	A participating provider who: (1) practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology; and (2) acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals for specialists for their assigned members.
Prudent Layperson	A prudent layperson is considered to be a person who is without medical training and who draws on his or her own practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

Subscriber	The person whose employment or other status, except for family dependency, is the basis for eligibility in the Plan.
Terminated Provider	A provider whose contract to provide services to WHA members is terminated or not renewed.
Underutilization	Failure to provide appropriate or indicated services, or provision of an inadequate quantity or lower level of services than required.
Urgent Care Services	Services that are medically required within a short time frame, usually within 24 hours, to prevent a serious deterioration of the member's health due to an unforeseen illness or injury. Urgent care requires prompt attention and although it may not be life threatening, the situation has the potential to become an emergency in the absence of treatment.

15. Appendix

Appendix 1-Preventive Services Covered Without Cost Sharing - All Other Commercial

APPENDIX A*
Preventive Services Covered Without Cost-Sharing

The following preventive services are covered without copayment or cost-sharing. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

Service	Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening[1]	x			
Abnormal Blood Glucose and Type 2 Diabetes Mellitus, Screening[2]	x	x		
Alcohol Misuse, Screening and Behavioral Counseling	x	x		
Annual Well Visits for Children[3]				x
Annual Well Visits for Men[4]	x			
Annual Women's Well Visits[5]		x		
Aspirin – low dose for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication[6]	x	x		
Asymptomatic Bacteriuria, Screening[7]			x	
Autism Screening by PCP[8]				x
Behavioral Counseling in Adults with Cardiovascular Risk Factors	x	x		
Birth Control[9]		x		
Blood pressure screening in children[10]				x
BRCA-Related Cancer in Women, Screening – Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[11]		x		
Breast Cancer, Preventive Medications		x		
Breast Cancer, Screening[12]		x		
Breastfeeding Support, Supplies and Counseling[13]		x	x	
Cervical Cancer, Screening[14]		x		
Chlamydial Infection, Screening[15]		x	x	
Colorectal Cancer, Screening including Bowel Prep[16]	x	x		
Congenital Hypothyroidism, Screening[17]				x
Dental Caries in Preschool Children, Prevention[18]				x
Depression in Adults, Screening[19]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[20]	x	x		
Domestic Abuse, Screening and Counseling	x	x		x
Drug Use Screening in Adults 18+, Unhealthy	x	x		

Service	Men	Women	Pregnant Women	Children
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication (Generic Required, Brand Name is Not Covered)[21]		x	x	
Gestational Diabetes Mellitus, Screening[22]			x	
Gonorrhea, Ocular Prophylactic Medication[23]				x
Gonorrhea, Screening[24]		x	x	
Group B Streptococcus, Screening			x	
Hearing Loss in Newborns, Screening[25]				x
Hepatitis B Virus Infection in Pregnant Women, Screening[26]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult[27]	x	x		x
Hepatitis C Virus Infection, Screening[28]	x	x		x
High Blood Pressure in Adults 18+, Screening	x	x		
HIV, Screening[29]	x	x	x	x
HPV, Screening[30]		x		
Immunizations[31]	x	x		x
Intimate partner violence screening: women of reproductive age[32]		x		
Iron Deficiency – Anemia, Prevention – Counseling by PC[33]			x	x
Latent TB Infection, Screening[34]	x	x		x
Lead, Screening for at-risk children				x
Lipid Disorders in Adults, Screening[35]	x	x		
Lung Cancer, Screening[36]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[37]				x
Obesity in Adults, Screening[38]	x	x		
Obesity in Children and Adolescents, Screening[39]				x
Osteoporosis, Screening[40]		x		
Phenylketonuria (PKU), Screening[41]				x
Perinatal Depression: Preventive Interventions		x	x	
Postpartum Care			x	
Preeclampsia, Prevention: Low-dose Aspirin[42]			x	
Preeclampsia, Screening			x	
Prenatal Screening Under the California Prenatal Screening Program[43]			x	
Prevention of HIV Infection: Preexposure Prophylaxis[44]	x	x	x	x
Rh (D) Incompatibility, Screening[45]			x	

Service	Men	Women	Pregnant Women	Children
Sexually Transmitted Infections, Counseling[46]	x	x		x
Sickle Cell Disease in Newborns, Screening[47]				x
Skin Cancer, Counseling[48]	x	x		x
Statins for the Primary Prevention of Cardiovascular Disease[49]	x	x		
Syphilis Infection, Screening[50]	x	x	x	
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[51]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions[52]				x
Sterilization Procedures[53]	x	x		
Visual Impairment in Children Ages 1 to 5 Years, Screening[54]				x
Alpha-Fetoprotein Testing[55]			x	
Falls in Older Adults, Counseling, Preventive Medication and Other Interventions[56]	x	x		

Footnotes:

*This Appendix A includes the evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/) and, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or an OB/GYN who is a Participating Physician within your Medical Group or participating in Advantage Referral, and the primary purpose of the office visit must have been to obtain the preventive service. WHA and its Medical Groups may impose reasonable medical management techniques to determine the frequency, method, treatment or setting for a preventive service or item unless the particular guideline itself specifies otherwise. Except for the medications, supplements or items listed in Appendix A, WHA does not cover any medications, supplements or items that are generally available over the counter, even if the Member has received a Prescription for the medications, supplements or items.

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1 One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.

2 Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg. (Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.)

3 Children under age 18.

4 No-cost coverage provided by WHA but not mandated by state or federal law.

5 Women of all ages. Services for well-woman preventive visits may be completed at a single visit, or as part of a series of preventive health visits that take place over time to obtain necessary services.

6 Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

7 Pregnant women at 12 to 16 weeks gestation or at first prenatal visit, if later.

8 Infants at 9 months, 18 months, 24 months or 30 months.

[9] Birth control pills are no-cost for Generic only. Includes prescribed morning-after pill for women under age 17. WHA covers FDA-approved contraception for women with no copayment or cost sharing. See the section entitled "Family Planning" for the FDA-approved birth control methods. Birth control is not covered if excluded by your plan consistent with Federal and state law.

[10] Blood Pressure screening should occur in infants and children with specific risk conditions at visits before age 3 years.

[11] Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes for genetic counseling and evaluation for BRCA testing.

[12] Mammography every 1 to 2 years for women 40 and older. Three-dimensional ("3D") mammograms are not considered preventive.

[13] Lactation support, supplies and counseling during pregnancy and post-partum to promote and support breastfeeding.

[14] Women aged 21 to 65 who have been sexually active and have a cervix.

[15] Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.

[16] Adults aged 45 to 75 years as recommended by your physician. Colonoscopies are also covered for a positive result on a non-colonoscopy test or procedure.

[17] Newborns.

[18] Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.

[19] In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.

[20] Adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared).

[21] Recommendation that women pregnant or planning on pregnancy have folic acid supplement.

[22] Pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

[23] Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.

[24] Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.

[25] All newborns by one (1) month of age; enrolled in early treatment if identified as hard of hearing by age six (6) months.

[26] Pregnant women at first prenatal visit.

[27] Adolescents and adults at increased risk.

[28] Recommended screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

[29] All adolescents and adults aged 15 to 65 years, and all pregnant women.

[30] Every three years for women 30 and older.

[31] Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).

[32] Screening for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.

[33] Perform risk assessment or screening, as appropriate, per recommendations in current edition of American Academy of Pediatrics ("AAP") Pediatric Nutrition: Policy of the AAP (Iron chapter). In pregnant women, it is critical to distinguish iron deficiency anemia from physiologic anemia, as well as to identify other less common causes of anemia that may require treatment.

[34] Those at increased risk.

[35] For patients at higher cardiovascular risk (hypertension, diabetes mellitus, cigarette smoking, family history of premature CHD), it is suggested that follow-up lipid screening be performed in males between the ages of 25 to 30 and in females between the ages of 30 to 35. For patients at lower cardiovascular risk (none of the above factors), it is suggested that follow-up lipid screening be performed in males at age 35 and in females at age 45.

[36] Annual screening with low-dose computed tomography in adults ages 50 to 80 years who have a 20-pack/year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has

not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

[37] Adolescents age 12 to 18 when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.

[38] Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

[39] Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese children.

[40] Women 65 and older and women younger than 65 at increased risk for osteoporotic fractures.

[41] Newborns.

[42] Use of low-dose aspirin after 12 weeks of gestation in women who are at high risk for preeclampsia.

[43] Once each month at weeks 4 through 28; twice a month at weeks 28 through 36; weekly at weeks 36 to birth.

[44] Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk for HIV acquisition.

[45] Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D)-negative women at 24 to 28 weeks gestation unless biological father is known to be Rh (D) negative.

[46] All sexually active adolescents and adults at increased risk for sexually transmitted infections.

[47] Newborns.

[48] Counseling for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

[49] Low to moderate-dose statins for adults aged 40 to 75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk 10% or greater.

[50] Persons at increased risk and all pregnant women.

[51] Discussion/counseling about tobacco cessation interventions for those who use tobacco, and education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered. Brand name medication Chantix will be covered at no cost if specifically prescribed with a "do not substitute" or "prescribe as written" indication by a physician. Over-the-counter patches, gum, and lozenges are covered for two cessation attempts per year when prescribed by a physician.

[52] Discussion/counseling about tobacco cessation interventions for those who use tobacco, and education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered. Brand name medication Chantix will be covered at no cost if specifically prescribed with a "do not substitute" or "prescribe as written" indication by a physician. Over-the-counter patches, gum, and lozenges are covered for two cessation attempts per year when prescribed by a physician.

[53] Includes male sterilization procedure (vasectomy). Includes female sterilization procedures performed in connection with another procedure, such as cesarean delivery or abortion. Sterilization procedures for contraceptive purposes are not covered if excluded by your plan consistent with Federal law.

[54] To detect amblyopia, strabismus, and defects in visual acuity.

55 Once per pregnancy for pregnant individuals between 15 and 20 weeks' gestation.

56 Preventive care visits to discuss exercise interventions to prevent falls is a covered service for patients who are meet all of the following criteria: community-dwelling adults (excluding institutionalized, facility-based adults, such as those in Skilled Nursing Facilities), age 65 years or older, and at increased risk for fall.

Appendix 2-Medical Record Management and Documentation Standards

Medical Record Management and Documentation Standards

Western Health Advantage

MEDICAL RECORD MANAGEMENT STANDARDS

1. Medical Group/IPA practitioners must have written processes or policies/procedures addressing the management of medical record systems/documentation standards/medical record keeping practices at practitioner sites that include specifics related to the following standards. These documents are made available to the health plan, regulatory and accreditation agencies upon request.
2. Medical Group/IPA practitioners must maintain an individual hard-copy or electronic medical record (EMR) for each member. Electronic medical records or member data must:
   - Be password protected
   - Contain a list of signatures by initials
   - Include a system to incorporate electronic data into hardcopy medical records when both are used
3. The medical record keeping system must ensure:
   - The medical record is made available to the practitioner at the time of a member encounter,
   - Information can be retrieved easily and promptly,
   - Information is filed in the medical record timely (reports such as lab, x-ray, consultations, etc),
   - Hard-copy records are filed systematically either alphabetically, numerically, or color coded.
   - Hard-copy medical records and other protected health information are collected after use and stored in a secure central place accessible only to authorized personnel.
4. Hard-copy and electronic medical records that are in use, are maintained in such a manner that the contents cannot be viewed by persons unauthorized to access such records.
5. Medical Group/IPA practitioners and their staff have a documented system for tracking hard-copy medical records when a record is removed from the centralized filing system. (Mental health and substance abuse records may be filed separately from the member's main medical record.)
6. Medical Group/IPA practitioners and their staff have a documented system in place to follow-up on referrals, procedures or tests cancelled for cause by the member, and laboratory, x-ray, consultation reports or other information that hasn't been reviewed.
7. Medical Group/IPA practitioners and their staff have a documented system in place to ensure that inactive records and purged hardcopy and electronic medical data are archived in a manner that meets federal and state requirements. Medical Records should be retained in California for a minimum of 10 years after the date of last service, as recommended by the California Medical Association. It is required, additionally, for at least 1 year past the age of majority for minors.
8. Medical Group/IPA practitioners and their staff have a documented system in place to obtain Consent for Treatment given by the member, parent, or guardian at the initial office visit by signing a Consent to Treatment form filed in the member's medical record. Any special consent forms signed must be present in the member's medical record.
9. Release of hard-copy or electronic medical records are provided only by Medical Record Department or Health Information Management staff or personnel with responsibility for such release of information. There is documented evidence that staff have received periodic training regarding HIPAA Privacy Regulations and maintaining confidentiality of member information.
10. Member protected health information is released in accordance with the HIPAA Privacy regulations and any other applicable federal or state regulations. Authorization forms permitting the release of medical records specify all of the items set forth in the HIPAA regulations (including the type of information requested, name of requestor, name/ ID/DOB of member, dated signature of member or authorized representative, date of request, and date of release). Release of information in response to a court order or other legal process is reported to the member when required by HIPAA.

MEDICAL RECORD DOCUMENTATION STANDARDS

1. *Each page in the medical record contains the patient's name or ID number.*
2. *All entries must be legible, containing the author's identification and valid signature, with each entry dated.*
3. *The medical record contains a medication list, which includes all current and previously ordered medications.*
4. **Medication allergies/adverse reactions are clearly noted. No known allergies or history of adverse reactions are appropriately documented.*
5. **Past medical history is easily identified and includes significant illnesses, serious accidents, operations, and medical conditions.(Members seen three or more times)*
6. **The medical problem list includes significant illnesses and medical conditions.*
7. **The working diagnoses are consistent with the findings.*
8. **Treatment plans are consistent with the diagnoses and there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.*
9. *Medical Specialists reports, significant telephone consultations, Pathology, Laboratory and other diagnostic and screening reports are filed in the medical record.*
10. *Medical Specialists reports, significant telephone consultations, Pathology, Laboratory and other diagnostic and screening reports are filed in the medical record.*
11. *When indicated, documentation regarding Consultations and/or Specialists Referrals, follow-up care, calls or visits is noted in the encounter.*

Standards #4, #5, #6, #7, #8 are Core Components to Medical Record Documentation.

PROVIDER REVIEW PERFORMANCE CRITERIA

Audit scores	Review Frequency	Corrective Action Plan
90% or above	Every three years	None needed
70 – 89%	Every year	May be required as needed based on safety, security, grievances or other issues
Below 70%	Every year	Required

Appendix 3: Member Rights and Responsibilities Statement

Member Rights and Responsibilities Statement

Western Health Advantage

GENERAL INFORMATION

WHA's Member Rights and Responsibilities outline not only the Member's rights but also the Member's responsibilities as a Member of WHA. You may request a separate copy of this Member Rights and Responsibilities by contacting our Member Services staff. It is also available on the WHA website at westernhealth.com.

Member Rights

Member rights may be exercised without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. Western Health Advantage member rights include the following:

- To be provided information about the WHA organization and its services, providers/practitioners, managed care requirements, processes used to measure quality and to improve member satisfaction, and their rights and responsibilities as a member.
- To be treated with respect and recognition of their dignity and right to privacy.
- To actively participate with practitioners in making decisions about their health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending physician.
- To expect candid discussion of appropriate, or medically necessary, treatment options regardless of cost or benefit coverage.
- To voice a complaint about the organization and/or appeal a decision to WHA, or the care it provides, and to expect that a process is in place to ensure timely resolution of the issue.
- To make recommendations regarding WHA's member rights and responsibilities policies.
- To know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of others who may provide services including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about their illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for them to make an informed decision to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment; medically significant risks associated with it; alternate courses of treatment or non-treatment including the risks involved with each; and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with their care, except as permitted by law or as necessary in the administration of the health plan. WHA's policies related to privacy and confidentiality are available upon request.
- To full consideration of privacy and confidentiality around the members' plan for medical care, case discussion, consultation, examination and treatment including the right to be advised of the reason an individual is present while care is being delivered.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment as well as the name of the practitioner scheduled to provide their care.
- To be advised if the physician proposes to engage in, or perform, human experimentation within the course of care or treatment, and the ability to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner's office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these member rights apply to a person with legal responsibility for making medical care decisions on their behalf. This person may be their physician.
- To have access to their personal medical records.
- To formulate advance directives for health care.

See reverse for Member Responsibilities

Member Responsibilities

It is the expectation of WHA and its providers that enrollees adhere to the following member responsibilities to facilitate the provision of a high level quality of care and service to members. These responsibilities include, but are not limited to, the following:

- To know, understand and abide by the terms, conditions and provisions set forth by WHA as their health plan. This information is contained in the Evidence of Coverage & Disclosure Form (EOC/DF) that is received at the time of enrollment and/or available online via mywha.org.
- To supply WHA and its providers and practitioners (to the extent possible) the information they need to provide care and service to WHA members. This includes informing WHA's Member Service Department when a change in residence occurs and/or when other circumstances arise that may affect entitlement to coverage or eligibility.
- To select a primary care physician (PCP) who will have primary responsibility for coordination of care, and to establish a relationship with that PCP.
- To learn about their medical condition and health problems, and to participate in developing mutually agreed upon treatment goals with their health care practitioner(s)to the degree possible.
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that the member agreed to with their health care provider(s), and provide those professionals information relevant to the members care.
- To schedule appointments, as needed or indicated, and/ or to notify their health care practitioner(s) when it is necessary to cancel an appointment and to reschedule cancelled appointments, if indicated.
- To show consideration and respect to the practitioners and their staff and to other patients.
- To express grievances regarding WHA, or the care or service received through one of WHA's providers, to WHA's Member Service Department for investigation through WHA's grievance process.

Appendix 4: Continuity of Care Form

Continuity of Care Request Form

Western Health Advantage

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833 | **Fax to:** 916.568.0278

Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

If you are currently receiving treatment and (i) a new WHA member or (ii) an existing WHA member whose physician has terminated with WHA, you may request to temporarily remain with your existing physician. Please see the back for more information about what continuity of care is and if you may be eligible. To request continuity of care, complete this form for each physician you want to retain. If you do not have a qualified continuity of care issue, you may still request assistance in changing to WHA providers by using this form. Turn this form into WHA as soon as you know you will need continuing care (if new) or of when your physician terminated with WHA. WHA will let you know if you qualify for continuity of care.

Note: Effective 1/1/23, for behavioral health continuity of care requests, please call Optum: Individual/Group plan members, call 800.765.6820; Medicare Advantage plan members, call 855.857.9748. To verify if a current mental health provider is in the network, Optum's network directory is searchable at www.liveandworkwell.com. For Individual/Group members, use access code: WHA; for Medicare Advantage members, use access code: WHAMedicare.

REQUEST FOR: ❑ Continued Care With Current Specialist ❑ Assistance With Changing Specialist/Provider

SECTION I — MEMBER AND PLAN INFORMATION

Member First Name_____ Last Name_____ MI_____

Date of Birth_____ WHA Member ID#_____ WHA Effective Date_____

Address_____ Apt./Unit#_____

City, State, Zip_____ Home Phone_____

Work Phone_____ Previous Health Insurance Carrier_____ ❑ HMO ❑ PPO

Employer_____

SECTION II — PATIENT, PHYSICIAN AND TREATMENT INFORMATION

Patient Name_____ Diagnosis_____

Relationship to Employee_____ Date of Birth_____ Phone_____

Address (if different)_____ Apt./Unit#_____

City, State, Zip_____

Primary Care Physician_____ Medical Group_____

Out-of-Network Providers

Requested Specialist_____ Specialty_____ Phone_____

Specialist Address_____ Suite#_____

City, State, Zip_____

Is patient pregnant? ❑ Yes ❑ No Due Date_____ Delivering Hospital_____

Date of initial diagnosis/treatment_____ Is patient currently receiving treatment? ❑ Yes ❑ No

Date of next scheduled treatment/appointment_____

Current treatment/need (provide details, use separate sheet if necessary)

_____

_____

SECTION III — SIGNATURE REQUIRED

I authorize the medical providers listed above to disclose all medical records to Western Health Advantage (WHA) for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after WHA completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and WHA are required under state and federal law to keep my medical information confidential. I understand that WHA will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

Patient Signature_____ Date_____

WHA 219 Continuity of Care Form | Last reviewed or revised by WHA: 11.22

page 1 of 2

Continuity of Care Request Form

Western Health Advantage

WHAT IS CONTINUITY OF CARE?

In certain circumstances (below), you may temporarily continue care with a physician who is not part of WHA's network (a "Non-Participating Provider"). If you are being treated by a provider who has been terminated from WHA's network, or if you are a new Member who has been receiving care from a Non-Participating Provider, you may continue care with that provider if you meet the continuity of care requirements explained below.

CONTINUITY OF CARE REQUIREMENTS

In order for you to be eligible for continued care, the Non-Participating Provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis.

- An acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition: a serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the member and the terminated provider or Non-Participating Provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled member.
- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period including a documented maternal mental health condition (care continued no longer than twelve (12) months from the end of the pregnancy)).
- A terminal illness: an incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and thirty-six (36) months. Care shall be continued for up to twelve (12) months.
- Performance of surgery or other procedure that has been authorized by WHA (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

NOTE ABOUT PROVIDERS

WHA and/or the medical group may require the Non-Participating Provider to agree to WHA's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not comply with these contractual terms and conditions, you will not be eligible to continue care with that provider.

If you have questions about Western Health Advantage's continuity of care policy, please call our Member Services Department.

Appendix 5: Chronic Care or Condition Management Referral Form

Chronic Care/Condition Management
REFERRAL FORM

westernhealth ADVANTAGE

Mail to: Western Health Advantage, Attn: Population Health Management Department
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0278
Email to: healthpromotions@westernhealth.com
Questions? 916.563.2250, 888.563.2250 toll-free or 711 for TTY

Sender Information Date _____

Contact Name (First Last) _____

Phone Number _____ Email _____

Patient Information

Name (First Middle Initial Last) _____

Phone Number _____ WHA ID # _____

❑ Is the patient a WHA subscriber? **Skip WHA Subscriber Information**

WHA Subscriber Information

Name (First Middle Initial Last) _____

Street Address _____ City State Zip _____

Physician Information

Name (First Last) _____ ❑ PCP ❑ Specialist

Office Phone _____ Other Phone _____

CHRONIC CARE/CONDITION MANAGEMENT PROGRAMS

Please check all that apply: ❑ Asthma ❑ Coronary Artery Disease (CAD) ❑ Congestive Heart Failure (CHF)
❑ Chronic Obstructive Pulmonary Disease (COPD) ❑ Diabetes, type 1 and type 2

Check with your benefits advisor or WHA Member Services to determine if these programs are available to you:
❑ Pregnancy & Postpartum Support ❑ Diabetes Prevention Program

Reason for Referral (Optional)

_____

_____

_____

_____

_____

WHA OFFICE USE ONLY

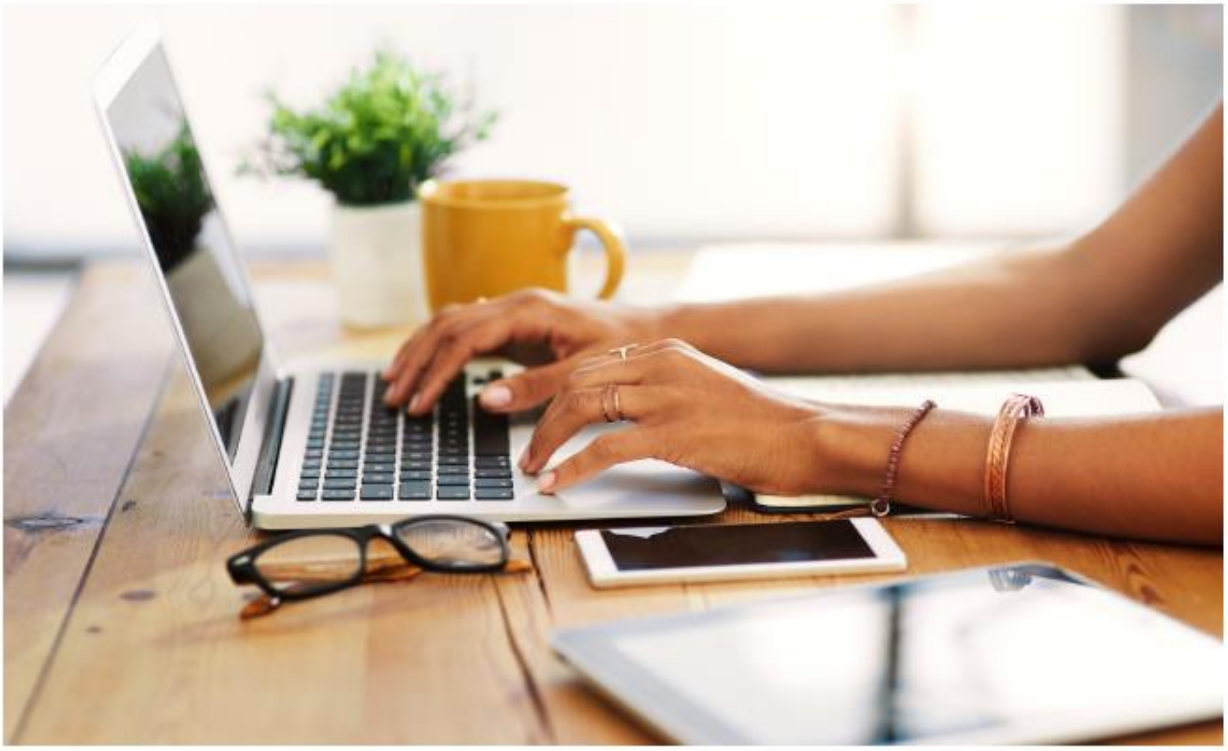
Date Received _____ Processed By _____

Date Sent to Optum _____ Follow-up Date _____

Appendix 6: WHA Member Complaint Form

Western Health Advantage

FILING A GRIEVANCE



PUBLISHED JANUARY 2022

advantage you

Western Health Advantage's goal is to provide its members with the optimum quality and member service experience. To this end, WHA has established a formal process for addressing member concerns, complaints, grievances and appeals.

What is a Grievance?

A grievance is any written or oral expression of dissatisfaction made by you, your representative or your provider regarding your experience with WHA, your medical group or any WHA participating provider. The grievance can be related to a payment issue, an administrative action or quality of care or service issue. A "standard" or routine grievance is usually investigated and resolved within 30 calendar days. A "fast track" or expedited grievance is completed within 72 hours from receipt of the formal complaint.

What is an Appeal?

An appeal is a verbal or written formal request to re-review or reconsider a decision that has been made. The appeal can be related to a payment denial, an administrative action, or utilization recommendation. Your appeal will be reviewed by a doctor who was not involved in the initial review of the issue. This doctor will make an independent second decision after reviewing all available information. The second decision may agree or disagree with the first decision.

Standard or routine appeals are completed within 30 calendar days. A delay in a final decision may occur if additional information is needed for the reviewer to make an informed decision. Expedited or "fast track" appeals are completed within 72 hours upon request if delaying the appeal decision risks jeopardizing your health. You have the right to request a "fast track" or expedited appeal if your doctor agrees there are health risks in delaying the decision. WHA's Medical Director will make the decision as to whether the appeal will be handled as an expedited or standard appeal.

What is WHA's Grievance and Appeal Procedure?

If you have a complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other complaint, please call Member Services for immediate assistance.

If your complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written grievance or appeal may be submitted to:

Mail:	Western Health Advantage Attn: Appeals & Grievances 2349 Gateway Oaks, Suite 100, Sacramento, CA 95833
Secure fax:	916.563.2207
Call:	916.563.2250 or 888.563.2250 or 888.877.5378 TDD/TTY
Email:	appeal.grievance@westernhealth.com
Online form:	**mywha.org/grievance**

Please complete the attached form. Be sure to include a discussion of your questions or situation and your reasons for dissatisfaction. Submit the grievance or appeal to WHA's Member Services or Appeals & Grievances departments within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you may request a review by WHA or go directly to the Department of Managed Health Care. If your coverage is still in effect when you submit your grievance, your coverage will be continued while your grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the grievance, including any appeal to the California Department of Managed Health Care, if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All premiums must be up to date and paid timely.

WHA will send an acknowledgment letter to you within five (5) calendar days of receipt of your grievance or appeal. A determination is rendered within thirty (30) calendar days. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the grievance or appeal will be provided to the Member and will include an explanation of the contractual or clinical rationale for the decision.

A grievance form and a description of the grievance procedures are available at every Medical Group and Plan facility. In addition, a grievance form will be promptly mailed to you if you request one by calling Member Services. If you would like assistance in filing a grievance or an appeal, please call Member Services and a representative will assist you in completing the form or explain how to write your letter. We will also be happy to take the information over the phone verbally or through a secure message via your online MyWHA account.

For detailed information about the grievance and appeal procedure visit **mywha.org/grievance** or call WHA Member Services at 916.563.2250 or 888.563.2250.

Terminal Illness Conference

If WHA has denied treatment, services or supplies deemed experimental and you have a terminal illness (a condition that has a high probability of causing death within one year or less), you can request a conference as part of the grievance system. Please indicate on the grievance form your request for a conference.

Plan Partner Grievances

If you have a grievance about your dental, vision or mental health services, visit **mywha.org/grievance** for special instructions.

Language Assistance

WHA wants to ensure all Members have access to the grievance and appeal system. WHA provides free-of-charge verbal and written translation services to those with limited English proficiency or with visual or other communicative impairments. Please contact WHA's Member Services Department for more information or visit **mywha.org/grievance** for more information.

GRIEVANCE/APPEAL REQUEST FORM

Mail to: Western Health Advantage, Attn: Appeals and Grievances
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.563.2207
Email to: appeal.grievance@westernhealth.com
Direct questions to: 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY
This form is also available online mywha.org/grievance

Member Name_____ Member ID Number_____

Street Address_____

City, State, Zip Code_____ Birth Date_____

Daytime Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Alternate Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Name of Person Filing _____

(If Different Than Above, Please Complete the Attached Authorized Assistance Form)

Relationship_____ Daytime Telephone Number_____

Department/Location or Medical Facility Where Issue Occurred_____

Date(s) Issue(s) Occurred_____

Please Describe the Nature of the Issue(s) — Attach Additional Sheets if Needed

Please Explain How You Have Tried to Resolve the Issue(s)

What Would You Consider a Proper Solution to the Issue(s)?

Signature_____ Date_____

❑ Check Here If You Are Requesting A Terminal Illness Conference

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-563-2250 (TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function) or if your grievance involves and/or is related to cancellation, rescission, or renewal of your plan enrollment, subscription, or contract, you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

For Internal Use Only: WHA Representative Name_____ Date Received_____

Authorization For Use or Disclosure of Health Information

Western Health Advantage

Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0126
Email to: memberservices@westernhealth.com
Include in Subject Line: Authorization for Use or Disclosure
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY

A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

1. Member whose information is to be disclosed

Name: _____

Address: _____

Member ID Number: _____ Date of Birth: _____

2. Person (the "Recipient") authorized to receive the Member's information

Recipient's Name: _____ Relationship to Member: _____

Recipient's Address: _____

3. Information to be disclosed to the Recipient (check only one of the three options)

❑ All information that WHA maintains, excluding Sensitive Information unless specifically authorized in section 4.

OR ❑ Only the following information, or types of information, WHA maintains: (check all that apply)

- ❑ Medical Information (diagnosis, treatment, medication, including authorizations and referral status)
- ❑ Health Plan Coverage and Eligibility
- ❑ Financial/Billing Information (e.g. Premium payments), excluding claims information
- ❑ Claims Status/Payment Information
- ❑ Other _____

OR ❑ Psychotherapy notes

If you check this box, you may not check any of the other boxes in this section or in section 4. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information; a separate form must be used.

4. Is the Recipient also authorized to receive Sensitive Information as described below?

❑ NO ❑ YES If Yes, I specifically authorize WHA to release to Recipient:

❑ All sensitive information OR ❑ Only the following information: (check all that apply)

- ❑ Alcohol/substance abuse ❑ Mental health ❑ Genetic information
- ❑ Sexually transmitted illness (including HIV/AIDS)
- ❑ Sexual, physical, or mental abuse
- ❑ Abortion/reproductive health (including pregnancy, contraception)

5. Reason for this authorization (check only one)

❑ Personal Use ❑ Legal ❑ Other (please specify): _____

6. Authorization to Act on Member's Behalf

I authorize the Recipient to perform the following acts:

- ❑ Enroll me/disenroll in/from Plan
- ❑ Choose/change my PCP
- ❑ Request new ID Card
- ❑ Change/correct missing/erroneous demographic information
- ❑ All of the above

B. Expiration

This authorization will remain in effect:

❑ for one (1) year from the date of your signature below, OR

❑ until Month _____ Day _____ Year_____ (this period cannot be longer than 3 years from the date of signature below)

C. Notice to Member

- You can revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information WHA used or disclosed before receipt of the revocation request.
- WHA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether you or your representative sign this authorization.
- If this authorization is on behalf of a minor,
  - o federal and state laws may prohibit WHA from acting on your request about Sensitive Information without written authorization from the minor 12 years of age or older;
  - o it will expire when the minor turns 18 or is legally emancipated, or may be revoked by the legally capacitated minor.
- State law prohibits the re-disclosure of medical information by a Recipient without a separate authorization. If the requested information is re-disclosed, it may no longer be protected by federal privacy laws.
- If the requested information is Substance Abuse Information, this was disclosed from records protected by federal confidentiality rules. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- You are entitled to a copy of this form.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

D. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I am signing this form of my own free will.

Signature_____ Date_____

Print Name_____

Relationship to Member (if applicable):_____

Personal or legal representatives or guardians: If this form is signed by someone other than the Member or the parent of a minor, this authorization must be accompanied by documentary proof of the authority to act on behalf of the Member (or the Member's estate).

Keep a copy of this Authorization for your records.

WHA Internal Use Only

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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 at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث أدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره888.877.5378 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصو صWestern Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرو رية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

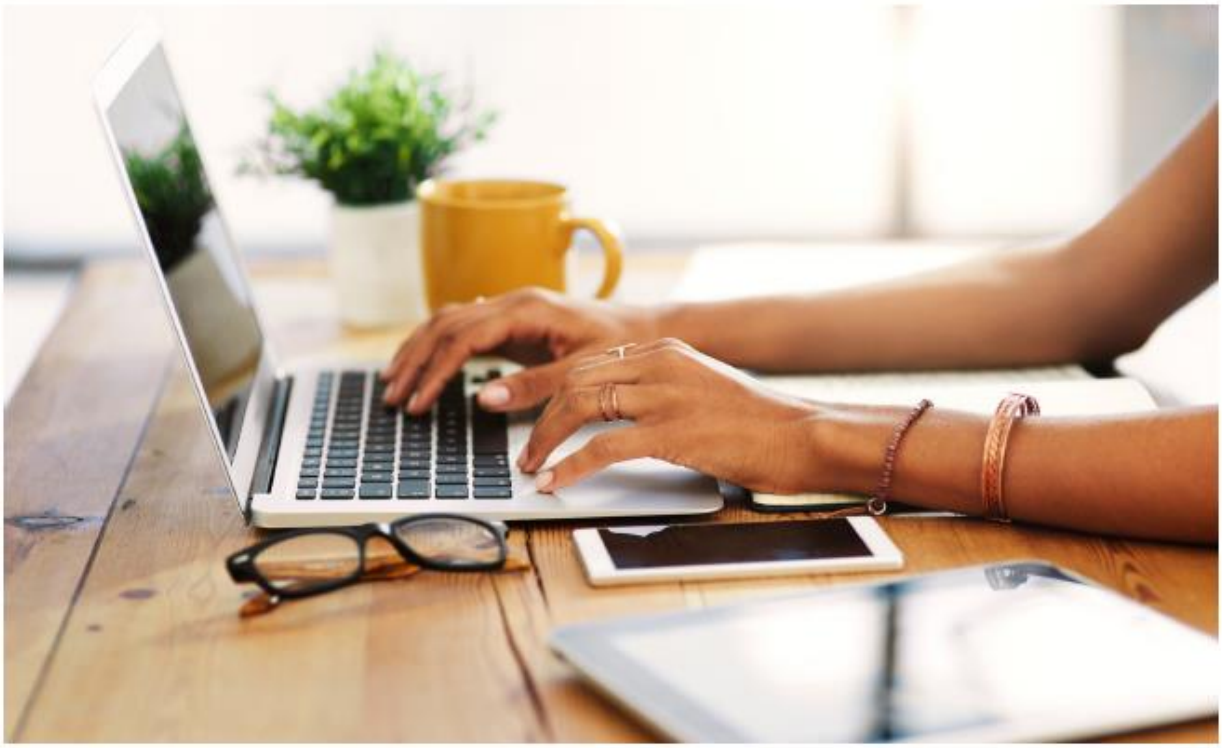
HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378

Appendix 7: WHA Member Complaint Form (Spanish)

Western Health Advantage

PRESENTACIÓN DE QUEJAS



PUBLICADO EN ENERO DE 2022

advantage you

El objetivo de Western Health Advantage es proporcionar a sus miembros una calidad y experiencia de servicio óptimas. Con este fin, WHA ha establecido un proceso formal para abordar preocupaciones, reclamos, quejas formales y apelaciones de los miembros.

¿Qué es una queja formal?

Una queja formal es cualquier expresión escrita o verbal de insatisfacción presentada por usted, su representante o su proveedor, acerca de su experiencia con WHA, su grupo médico o cualquier proveedor participante de WHA. La queja puede estar relacionada con un problema de pago, una acción administrativa o un problema de calidad de la atención o del servicio. Una queja formal "estándar" o de rutina generalmente se investiga y resuelve en un plazo de 30 días naturales. Una queja formal "acelerada" o expedita se completa en un plazo de 72 horas desde la recepción formal de la queja.

¿Qué es una apelación?

Una apelación es una petición formal, verbal o escrita, para que se vuelva a revisar o reconsiderar una decisión que se haya tomado. La apelación puede estar relacionada con una denegación de pago, una acción administrativa, o del servicio o una recomendación de utilización. Su apelación será revisada por un médico que no haya participado en la revisión inicial del problema. Este médico tomará una segunda decisión independiente después de revisar toda la información disponible. La segunda decisión puede estar de acuerdo o en desacuerdo con la primera decisión.

Las apelaciones estándar o de rutina se realizan en un plazo de 30 días naturales. Puede ocurrir un retraso en la decisión final si se necesita información adicional para que el revisor tome una decisión informada. Las apelaciones expeditas o "aceleradas" se completan en un plazo de 72 horas de la petición cuando retrasar la decisión de la apelación implicaría un riesgo para su salud. Usted tiene el derecho de solicitar una apelación "acelerada" o expedita si su médico está de acuerdo en que existen riesgos para la salud si se retrasa la decisión. El Director Médico de WHA tomará la decisión en cuanto a si la apelación se tratará como una apelación expedita o estándar.

¿Cuál es el procedimiento para quejas y apelaciones de WHA?

Si tiene una queja con respecto a que WHA no haya autorizado, proporcionado o pagado algún servicio que usted piensa tiene cobertura, sobre una cancelación, terminación, no renovación o rescisión de su membresía, o cualquier otra queja, llame a Servicios para Miembros para recibir asistencia inmediata.

Si su queja no se resuelve a su satisfacción después de hablar con un representante de Servicios para Miembros, puede presentar una queja o apelación verbal o por escrito a:

Correo postal:	Western Health Advantage Attn: Appeals & Grievances 2349 Gateway Oaks, Suite 100, Sacramento, CA 95833
Fax seguro:	916.563.2207
Teléfono:	916.563.2250 o 888.563.2250 o 888.877.5378 TDD/TTY
Correo electrónico:	appeal.grievance@westernhealth.com
Formulario en línea:	mywha.org/grievance

Complete el formulario adjunto. Asegúrese de incluir una explicación de sus dudas o su situación y sus motivos de insatisfacción. Presentar la queja o apelación a los departamentos de Servicios para Miembros o Apelaciones y Quejas de WHA dentro de los ciento ochenta (180) días posteriores al incidente o acción que causó su

insatisfacción. Si no puede cumplir con este plazo, comuníquese con Servicios para Miembros para que le informen cómo proceder.

Si está apelando una denegación de servicios incluidos dentro de un plan de tratamiento existente que ya se aprobó, la cobertura de los servicios aprobados continuará mientras se decide la apelación.

Si cree que su membresía se ha cancelado, rescindido o no renovado erróneamente, o que esto podría suceder, puede solicitar una reconsideración de WHA o acudir directamente al Departamento de Atención Médica Administrada. Si su cobertura aún está vigente al presentar su queja, su cobertura continuará vigente mientras se decide sobre su queja, incluso durante el tiempo de reconsideración por parte del Departamento de Atención Médica Administrada. Todas las primas deben seguirse pagando puntualmente para que la cobertura continúe. Al finalizar la queja, incluso cualquier apelación al Departamento de Atención Médica Administrada de California, si el tema se decide a su favor, su cobertura continuará o se le restituirá retroactivamente a la fecha en que se cobertura se terminó inicialmente. Todas las primas deben estar al día y pagarse puntualmente.

WHA le enviará una carta de acuse de recibo en un plazo de cinco (5) días naturales de la recepción de su queja o apelación. La determinación se presenta en un plazo de treinta (30) días naturales. WHA notificará al Miembro de la determinación, por escrito, en un plazo de tres (3) días hábiles de que se haya producido la decisión. Para apelaciones de denegaciones de cobertura o beneficios, se le otorgará la oportunidad de evaluar los contenidos del archivo y de entregar el testimonio a ser considerado. El Miembro recibirá una notificación escrita de la disposición de la apelación o queja que incluirá una explicación de los motivos contractuales o clínicos de la decisión.

En todas las instalaciones de Grupo Médico y del Plan puede encontrar un formulario de queja y una descripción de los procedimientos de queja. Además, si solicita un formulario de queja llamando a Servicios para Miembros, le será enviado por correo inmediatamente. Si desea ayuda para presentar una apelación o queja, llame a Servicios para Miembros, y un representante le ayudará a completar el formulario o le explicará cómo escribir su carta. Con gusto también aceptaremos la información oralmente por teléfono o envíe un mensaje seguro a través de su cuenta MyWHA en línea.

Para obtener información detallada acerca del procedimiento para presentar quejas y apelaciones, visite **mywha.org/grievance** o llame a Servicios para Miembros de WHA al 916.563.2250 u 888.563.2250.

Conferencia de enfermedad terminal

Si WHA ha negado tratamientos, servicios o suministros considerados experimentales, y usted tiene una enfermedad terminal (una afección que tiene una alta probabilidad de causar la muerte dentro de un año o menos), puede solicitar una conferencia como parte del sistema de quejas. Indique en el formulario de queja que solicita una conferencia.

Quejas sobre socios del Plan

Si tiene una queja acerca de sus servicios dentales, de la vista, de salud mental, acupuntura o quiroprácticos, visite **mywha.org/grievance** para obtener instrucciones especiales.

Asistencia con el idioma

WHA quiere asegurarse de que todos los Miembros tengan acceso al sistema de quejas y apelaciones. WHA ofrece servicios de traducción verbal y escrita, sin ningún costo, a personas con dominio limitado del inglés o con deficiencias comunicativas visuales o de otro tipo. Comuníquese con el Departamento de Servicios para Miembros de WHA o visite **mywha.org/grievance** para obtener más información.

FORMULARIO DE QUEJAS O APELACIONES

Enviar por correo a: Western Health Advantage, Attn: Appeals and Grievances
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Por fax a: 916.563.2207
Por correo electrónico a: appeal.grievance@westernhealth.com
Para obtener más información: 916.563.2250, 888.563.2250 gratis o 888.877.5378 para TDD/TYY
Disponible como formulario en línea en: mywha.org/grievance

Nombre Del Miembro _____ Número De ID Del Miembro _____

Dirección _____

Ciudad, Estado, Código Postal _____ Fecha De Nacimiento _____

Teléfono De Día _____ Dejar Mensaje ❑ Sí ❑ No

Teléfono Alternativo _____ Dejar Mensaje ❑ Sí ❑ No

Nombre De La Persona Que Presenta La Queja _____
(Si Es Diferente A La Indicada Arriba, Complete El Formulario De Asistencia Autorizada Adjunto)

Relación _____ Teléfono De Día _____

Departamento/Lugar O Centro Médico Donde Ocurrió El Problema _____

Fecha En Que Ocurrió El Problema _____

Describa La Naturaleza De Los Problemas (Adjunte Hojas Adicionales Si Es Necesario)

_____

_____

_____

Explique De Qué Manera Ha Intentado Resolver El Problema

_____

_____

_____

¿Qué Consideraría Una Solución Adecuada Para El Problema?

_____

_____

_____

Firma _____ Fecha _____

❑ Marque Aquí Si Está Solicitando Una Conferencia De Enfermedad Terminal

El Departamento de Atención Médica Administrada de California (DMHC) supervisa los planes de seguro médico. Si tiene una queja contra su plan de seguro médico, primero debe comunicarse con su plan de seguro médico al **888-563-2250 (TTY/TDD 1-888-877-5378)** y usar el proceso de queja de su plan de seguro médico antes de comunicarse con el departamento. Si cree que su cobertura de salud ha sido o será cancelada, rescindida o no renovada de manera incorrecta, también puede llamar al Departamento para solicitar asistencia. El uso de ese procedimiento de queja no prohíbe ningún remedio o derecho legal potencial que pudiera tener a su alcance. Si necesita ayuda con una queja que tiene que ver con una emergencia, una queja que no ha sido resuelta de manera satisfactoria por su plan de seguro médico o una queja que ha quedado sin resolver por más de treinta (30) días, puede llamar al departamento para solicitar ayuda. También es posible que califique para una Reconsideración Médica Independiente (IMR). Si califica para una IMR, el proceso de IMR facilitará una reconsideración imparcial de las decisiones médicas tomadas por el plan de seguro médico relacionadas con una necesidad médica de un servicio o tratamiento propuesto, decisiones de cobertura para tratamientos que son de naturaleza experimental o para investigación o disputas por servicios médicos de emergencia o urgentes. El departamento también tiene un número de teléfono gratuito, **888-466-2219**, y una línea TDD, **877-688-9891**, para las personas con problemas de audición o del habla. En el **http://www.dmhc.ca.gov** hay formularios de queja, formularios de solicitud de IMR e instrucciones en línea.

Si usted tiene un problema que involucra una amenaza inminente y grave para su salud (por ejemplo, dolor intenso o pérdida potencial de la vida, una extremidad o función corporal importante) o si su queja involucra y / o está relacionada con la cancelación, rescisión o renovación de la inscripción, suscripción o contrato de su plan, puede ponerse en contacto con el Departamento de Atención Médica Administrada de California directamente en cualquier momento sin antes presentarnos una queja.

For Internal Use Only: WHA Representative Name _____ Date Received _____

Appendix 8: Language Assistance Timeliness Standards

Western Health Advantage
Language Assistance Program Timeliness Standards

Statutory Requirement	Element	Timeliness Standards	Minimum Policy Requirements
CA Health and Safety Code 1367.04 (b) (1) (C) (ii) Upon request, the enrollee shall receive a written translation of the documents described in clause (i). The health care service plan shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the document that apply to the health care service plan and enrollees under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health care service plan's issuance of the translated document.	Request for translation of a non-standardized vital document is received from a member by the provider organization	*Urgent:* Response within one business day *Non-Urgent:* Response within two business days	*Urgent:* 1. Forward the following to the contracted health plan within one business day: a) request for translation b) copy of the document 2. Log the following: a) date request received from the member b) date request and document were forwarded to the health plan *Non-Urgent:* 1. Forward the following to the contracted health plan within two business days: a) request for translation b) copy of the document 2. Log the following: a) date request received from the member b) date request and document were forwarded to the health plan
CA H&SC 1367.04(b)(1)(C)(ii) as above	Request for a non-standardized vital document is received from a health plan by the provider organization	*Urgent:* Within one business day *Non-Urgent:* Within two business days	*Urgent:* 1. Forward the following to the contracted health plan within one business day: a) copy of the requested document 2. Log the following: a) date request received from the health plan b) date document was forwarded to the health plan *Non-Urgent:* 1. Forward the following to the contracted health plan within two business days: a) copy of the requested document 2. Log the following: a) date request received from the health plan b) date document was forwarded to the health plan

Statutory Requirement	Element	Timeliness Standards	Minimum Policy Requirements
28 CCR 1300.67.04 (c)(2)(G)(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.	Request for a plan-produced vital document received from a member by the provider organization	*All:* Within one business day	*All:* 1. Forward the following to the contracted health plan within one business day: a) request from the member 2. Log the following: a) Date request received from the member b) Date request forwarded to the health plan
A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling. [22 CCR 1300.67.04(c)(2)(A)&(B)]	Interpreter timeliness standards (Applies to non-delegated providers and plan personnel)	*Phone Interpretation (web/video):* Immediate, no more than 10 minutes from initial contact *Routine with in-person interpreter:* 5 business days *Urgent/Emergent:* For same day appointments, use phone interpretation as defined above. At Facilities under H & S Code 1259: Facilities are required to provide interpreter services.	*Phone Interpretation:* Timeframe begins at initial contact for LAP services and ends when the interpreter who speaks the LEP enrollee's language is connected. To provide *in-person* interpretation services, the appointment must be scheduled at least 5 business days in advance. Providers must allow at least 15 minutes for the interpreter to attend the appointment. Policy should refer providers to telephone/video based interpretations for same day, urgent or emergent care. If delays in providing services are identified, health plan interpreter services should be implemented to avoid further delay.

Appendix 9: Provider Dispute Resolution Request Form

Provider Dispute Resolution Request

Western Health Advantage

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Attention: Provider Dispute Resolution

Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

Please complete the below form. Fields with an asterisk (*) are required. Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.

Provider Information

*Provider NPI # _____ Provider Tax ID # _____

*Provider Name _____

Address _____ Suite # _____

City, State, Zip _____

Phone _____

Provider Type ❑ MD ❑ Mental Health Professional ❑ Mental Health Institutional ❑ Hospital ❑ ASC ❑ SNF ❑ DME
❑ Rehab ❑ Home Health ❑ Ambulance ❑ Other (please specify)_____

Claim Information

❑ Single ❑ Multiple "LIKE" Claims (complete attached spreadsheet) Number of Claims _____

*Patient Full Name (First Middle Initial Last) _____

Date of Birth _____ *Health Plan ID# _____

Patient Account # _____ Original Claim ID# _____
(If multiple, use spreadsheet)

Service "From/To" Date: (*Required for Claim, Billing and Reimbursement of Overpayment Disputes) _____

Original Claim Amount Billed $_____ Original Claim Amount Paid $_____

Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/Utilization Management Decision

❑ ❑ Seeking Resolution of a Billing Determination ❑ Contract Dispute

❑ ❑ Disputing Request for Reimbursement or Overpayment ❑ Other _____

*Description of Dispute _____

Expected Outcome _____

Print Name _____ Title _____

Signature _____ Date _____

Phone _____ Fax _____

❑ Check here if additional information is attached (please do not staple)

OFFICE USE ONLY Tracking # _____ Prov. ID# _____ Contracted ❑ Yes ❑ No

WHA Provider Dispute Resolution | Last reviewed or revised by WHA: 07.22

Provider Dispute Resolution Tracker

Western Health Advantage

INSTRUCTIONS

This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution. The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

Tracking # _____ Provider ID or NPI # _____

a. Provider Name _____ b. Contracted Provider ❑ Yes ❑ No

c. Date Dispute Received (Date Stamped) _____

d. Date of Initial Payment or Action _____

e. Was Dispute Received Within Time Frame? (c–d) ❑ Yes ❑ No (If No, should be returned to provider without action)

f.1. Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/UM Decision ❑ Billing Determination
❑ Overpayment Dispute ❑ Contract Dispute ❑ Other (Please specify) _____

f.2. Provider Type ❑ Professional ❑ Institutional ❑ Other _____

g. Date Dispute Acknowledged _____ h. Turnaround Time (g–c) _____

TYPE OF LETTER SENT List the various ICE letters as applicable

If no additional information requested:

j. Date of Action _____ k. Action Turnaround Time (j–c) _____

l. Type of Action ❑ Upheld ❑ Overturned ❑ Other _____

If additional information requested:

m. Date Additional Info Requested _____ n. Turnaround Time (m–c) _____

o. Date Addition Info Received _____ p. Receipt Turnaround Time (o–c) _____

q. Date of Action _____ r. Action Turnaround Time (q–o) _____

s. Type of Action ❑ Upheld ❑ Overturned ❑ Other _____

Complete description of determination rationale _____

WHA Provider Dispute Resolution | Last reviewed or revised by WHA: 07.22

Provider Dispute Resolution Request

FOR USE WITH MULTIPLE "LIKE" CLAIMS (Claims disputed for the same reason)

Western Health Advantage

	*Patient Last Name	*Patient First Name	Date of Birth	*Health Plan ID#	Original Claim ID#	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

❑ Check here if additional information is attached (please do not staple)

Page ____ of ____

WHA Provider Dispute Resolution | Last reviewed or revised by WHA: 07.22

Appendix 10: Provider Profile

Western Health Advantage
PROVIDER PROFILE

Contracted Medical Group:	

Provider Data			
Last Name:	First Name:	Middle Name:	Title:
Effective Date:	DOB:	PCP: *Yes* *No*	Gender: *M* *F*
Specialty: Primary:	Secondary:	HIV/AIDS Specialist: *Yes* *No*	
Provider Email:			
Supervising Physician:			
Language(s) Other Than English *Spoken by Physician*:			
Race of Provider: *(please select one)*			
☐ *American Indian or Alaskan Native*		☐ *White*	
☐ *Asian*		☐ *Other Race*	
☐ *Black / African American*		☐ *More than One Race*	
☐ *Native Hawaiian or Other Pacific Islander*		☐ *Decline to State*	
Ethnicity of Provider: *(please select one)*			
☐ *Hispanic or Latino*		☐ *Decline to State*	
☐ *Not Hispanic or Latino*			
Provider Panel: Status selected will be displayed on the Provider Directory *(please select one)*			
☐ *Accepting new patients*	☐ *Available by referral only*	☐ *Available only through a hospital or facility*	
☐ *Accepting existing patients*	☐ *Not accepting new patients*		
Employment: *Employed or Contracted*	ACE Screening Certified: *Yes or No*		
Include in Directory: *Yes or No*	Available for in-person urgent care appointments after hours? *Yes or No*		
Employment status: *Full Time (≥ 32 hours)* *Part Time (≤ 31 hours)*	Does the provider deliver some or all services via a telephonic or electronic modality? (Including video) *Yes or No*		

Licensure Information					
CA License:	Issued:	Expires:	DEA:	Expires:	
SSN:	Tax ID:	UPIN:	NPI:		
Malpractice Carrier:	Policy #:	Policy Limits:	Expires:		

Board Certification			
Status*:	Board Name:	Issue Date:	Renewal Date:
Status*:	Board Name:	Issue Date:	Renewal Date:
* BC – Board Certified NA – Not Applicable			

Practice Information				
Primary Address:	City:	Zip:	Office Hours:	
Phone:	Fax:	Office Email:		
Secondary Address:	City:	Zip:	Office Hours:	
Phone:	Fax:	Office Email:		
Billing Address:		City:	Zip:	
Phone:	Fax:	Billing Email:		
ADA Accommodations:				
☐ ADA - Exterior building ADA access		☐ ADA - Exam room ADA access		
☐ ADA - Interior building ADA access		☐ ADA - Exam table ADA access		
☐ ADA - Parking		☐ ADA - Wheelchair weight scale ADA access		
☐ ADA - Waiting or Reception ADA access		☐ ADA - Telecommunication device for deaf (TDD)		
☐ ADA - Restroom ADA access		☐ ADA - Braille Signage		

Education		
Medical School:	Specialty:	Graduated:
Internship:	Specialty:	Graduated:
Residency:	Specialty:	Graduated:
Fellowship:	Specialty:	Graduated:
Other:	Specialty:	Graduated:

Hospital Privileges	
Primary:	Status*:

Revised: March 2022

Western Health Advantage
PROVIDER PROFILE

Additional:	Status*:
Additional:	Status*:
* **AC** – Active **CU** – Courtesy **PR** – Provisional **CO** – Consultant **SR** – Surgical **LI** – Limited **AS** – Associate Staff **SU** - Suspended	

Revised: March 2022

Appendix 11: Prescription Drug Prior Authorization Request Form

Prescription Prior Authorization

Western Health Advantage

Western Health Advantage (WHA) utilizes prior authorization to ensure that drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. When prior authorization is required, requests for all self-administered medications (specialty and non-specialty) should be submitted to WHA for coverage determination. For additional details regarding pharmacy prior authorization criteria and access to our medical policies, you may create a secured account by requesting access on WHA's website (mywha.org/signup).

Prior authorization requests should be submitted directly to WHA to Fax # (916) 568-5280. State law requires that prescription prior authorization requests be made on the Prescription Drug Prior Authorization Request Form (Form No. 61-211 (12/16)), which can be obtained from:

- The provider section of the WHA website (westernhealth.com/provider)
- OptumRx (optumrx.com)
- Department of Managed Health Care (https://dmhc.ca.gov/HealthCareinCalifornia/ResourcesforHealthCareProviders.aspx#prescriptionpriorauth)
- Many electronic health record (EHR) systems

For quickest processing, ensure all information regarding the request is included on and/or with the form, including medical records and/or lab documentation if required by the medical policy.

The request must be processed within twenty-four (24) hours of receipt for exigent/urgent and within seventy-two (72) hours of receipt for nonurgent requests. "Exigent" means that a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function, or that the member is undergoing a course of treatment using a non-preferred drug. If no response is received within these timeframes, it is deemed approved. Exigent requests require documentation to support the exigent circumstance or they may be determined to be routine and processed within 72 hours.

Prior authorization requests for physician/office administered medications are covered under the medical benefit and should be submitted directly to the medical group's UM department for review.

Appendix 12: Commercial NOLA

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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 at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث آدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره888.877.5378 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378

Appendix 13: Commercial NOLA (Spanish)

Western Health Advantage cumple con las leyes de derechos civiles federales y de California aplicables y no discrimina por motivos de raza, color, origen nacional, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad o discapacidad, según corresponda. Western Health Advantage no excluye a las personas ni las trata diferente por motivos de raza, color, origen nacional, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad o discapacidad.

Western Health Advantage:

Proporciona ayudas y servicios gratuitos a las personas con discapacidades para comunicarse eficazmente con nosotros, tales como:

- Intérpretes calificados en el lenguaje de señas
- Información escrita en otros formatos (impresión grande, audio, formatos electrónicos accesibles, otros formatos)

Proporciona servicios gratuitos de idiomas a personas que no hablan inglés como idioma materno, tales como:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, póngase en contacto con el Administrador de Servicios para Miembros al 888.563.2250 y encuentre más información en línea en https://www.westernhealth.com/legal/non-discrimination-notice/.

Si usted cree que Western Health Advantage no ha brindado estos servicios o ha sido discriminado de otra manera por motivos de raza, color, origen nacional, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad o discapacidad, puede presentar una queja formal por teléfono, correo, fax, correo electrónico o en línea: Administrador de Servicios para Miembros, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 o 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form.
Si necesita ayuda para presentar una queja formal, el Administrador de Servicios para Miembros está disponible para ayudarlo. Para obtener más información sobre el proceso de queja formal de Western Health Advantage y sus derechos de queja formal ante el Departamento de Atención Médica Administrada de California, visite nuestro sitio web en https://www.westernhealth.com/legal/grievance-form/.

Si existe una preocupación de discriminación basada en raza, color, origen nacional, edad, discapacidad o sexo, también puede presentar una queja sobre derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles, electrónicamente a través del portal de la Oficina de Quejas sobre Derechos Civiles disponible en:

Sitio web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf; Por correo: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington, D.C. 20201; Teléfono: 800.368.1019 o 800.537.7697 (TDD); Los formularios de quejas están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث آدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره888.877.5378 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាននៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378