DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

ALAMEDA ALLIANCE FOR HEALTH

JANUARY 3, 2024

Behavioral Health Investigation
Alameda Alliance For Health
January 3, 2024

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

On May 9, 2022, the Department notified the Plan of its BHI covering the time period of April 1, 2020 through April 30, 2022. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan, its behavioral health delegate, Beacon Health Strategies, LLC[3] and its Pharmacy Benefit Manager (PBM), PerformRX, on September 7 and 8, 2022.

The BHI uncovered the following two Knox-Keene Act violations in the areas of Utilization Management, including Triage and Screening, and Quality Assurance:

1. The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855).
2. The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where violations are identified, and follow-up is planned where indicated.

Additionally, the Department identified three barriers to care not based on Knox-Keene Act requirements in the areas of Pharmacy, Cultural Competency and Health Equity, and Enrollee Experience.

---

[1] The Knox-Keene Health Care Service Plan Act of 1975 is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

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

[3] Beacon Health Strategies, LLC changed its name to Carelon Behavioral Health effective March 1, 2023. All references in this BHI Report refer to the Plan's behavioral health delegate as Beacon Health Strategies, the name in effect during the Plan's BHI review period.

1. The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.
2. Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.
3. Enrollees experience difficulties obtaining appointments.

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

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act violations. Recommendations to address and improve barriers to care not related to Knox-Keene Act violations will be included in the Department's Phase Two Summary Report.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

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

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

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

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. These included analyses of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[6] To evaluate the Plan's operations for the review period of April 1, 2020, through April 30, 2022, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and Pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

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

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were

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

compensated for their participation. Despite the Department's attempt to engage Plan enrollees and providers in interviews for this BHI, the Department received no response from either Plan enrollees or providers willing to be interviewed.

PLAN BACKGROUND

The Plan is a managed care plan in Alameda County and received its Knox-Keene license in September 1995. In January 1996, the Plan established itself as a public, not-for-profit health plan. The Plan primarily serves Medi-Cal enrollees, with 301,030 Medi-Cal enrollees. Its sole commercial product is an HMO benefit plan design for In-Home Supportive Services (IHSS) workers with 5,848 enrollees as of March 31, 2022.[7] The BHI did not extend to the Plan's Medi-Cal line of business and was limited to the Plan's commercial line of business, the IHSS product. For behavioral health services, the Plan contracts with Beacon Health Strategies, LLC. For pharmacy benefits, the Plan utilizes a PBM, PerformRX.

[7] Source: DMHC Dashboard 2022 Q1

SECTION I: KNOX-KEENE ACT VIOLATIONS

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#1: The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)

Statutory/Regulatory Reference(s): Sections 1374.72 and 1374.721

Supporting Documentation:

- Plan documents and communications submitted in eFiling # 20211181

Assessment: Effective January 1, 2021, all commercial full-service and behavioral health specialized health plans were required to comply with the requirements of Sections 1374.72 and 1374.721, enacted by SB 855 (Wiener, 2020). Among the requirements was the obligation to conduct utilization review for behavioral health services applying the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.[8]

Health plans were required to submit documentation to the Department's Office of Plan Licensing to demonstrate timely compliance with Sections 1374.72 and 1374.721. The Plan's submitted filings demonstrated the Plan was not in compliance with all requirements of Sections 1374.72 and 1374.721 as of January 1, 2021.[9]

The Plan's policy, UM-063, *Gender Affirmation Surgery and Transgender Services*, submitted February 4, 2022, was not in compliance with The World Professional Association of Transgender Health (WPATH) criteria more than one year after SB 855 went into effect. The Plan's policy included multiple requirements, conditions and limitations that are different, additional, conflicting or more restrictive than those described in WPATH Standards of Care criteria. For example, among other things, to be eligible for suppression of pubertal hormones treatments, the Plan's policy required an enrollee to have five years demonstrating gender nonconformity and to have lived publicly as the desired gender for at least 12 months, which are not required under WPATH.

The Plan was required to make multiple revisions to its policy to comply with SB 855. The Plan submitted its proposed revisions to the *Gender Affirmation Surgery and Transgender Services* policy in August 2022, some 18 months after SB 855 became effective.

Further, in May 2022, the Department required the Plan to make necessary changes to other Plan policies and procedures, including its utilization management program (UM-

[8] Section 1374.721(b).
[9] Plan response to Questionnaire, Utilization Management section, questions 8 and 9.

001) to include the required definition of "medically necessary treatment of a mental health or substance use disorder" described in Section 1374.72(a)(3)(A). The Plan submitted revised policies and procedures in June 2022, 16 months after SB 855 became effective. Finally, in October 2022, the Plan filed its evidence of coverage showing revisions made for compliance with SB 855.

The Department requested the Plan submit case files involving requests for behavioral health services requiring prior authorization. The Plan submitted 15 files, the universe of files for the review period. Ten of the 15 files involved requests for services after January 1, 2021, when SB 855 went into effect. Of the 10 files, four were for mental health services and six were for substance use disorder services. One file involving a request for mental health inpatient services demonstrated use of criteria not compliant with SB 855.[10]

Conclusion: Based on review of the Plan's submitted filings to the Department's Office of Plan Licensing, as well as Plan utilization management files, the Department finds the Plan failed to timely comply with the requirements of Sections 1374.72 and 1374.721.

QUALITY ASSURANCE

#2: The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(1)

Supporting Documentation:

- Four Potential Quality Issue files (April 1, 2020 – March 31, 2022)
- Plan policy *Potential Quality of Care Issues* Policy and Procedure (revised March 22, 2022)
- Seventh Amendment to Managed Behavioral Health Administrative Services Agreement (effective October 15, 2021)

Assessment: Section 1370 requires health plans to establish procedures in accordance with regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. To effectuate this requirement, Rule 1300.70(a)(1) states a health plan's quality assurance program must document that "the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated."

[10] Case File # 6. Notes demonstrate application of Adult and Geriatric Psychiatry InterQual criteria rather than Level of Care Utilization System (LOCUS) criteria.

Pursuant to the Seventh Amendment to Managed Behavioral Health Administrative Services Agreement (Agreement), the Plan delegates to Beacon Health Strategies the responsibility for compliance with quality improvement requirements as they pertain to behavioral health services, including those mandated by Rule 1300.70(a)(1). Among other things, the Agreement requires Beacon Health Strategies to analyze and evaluate the results of quality improvement activities and to assess performance of the quality and safety of clinical care and quality of service.

The Department reviewed relevant policies and procedures and potential quality issue files and conducted interviews with Plan and Delegate staff. The Plan's *Potential Quality of Care Issues* policy states, in part:

> In accordance with contractual agreement with [the Plan], participating delegates and its subcontracted providers will perform PQI activities in compliance with this policy and procedure.

Therefore, the Plan's policy requires Beacon Health Strategies to comply with the requirements and procedures set forth in the *Potential Quality of Care Issues* policy when performing delegated quality functions.

The Department requested both the Plan and Beacon Health Strategies provide a log of potential quality issue case files for the review period of April 1, 2020 to April 30, 2022. The Plan provided a universe of four files involving potential quality issues[11] that were referred to Beacon Health Strategies pursuant to the Agreement. Beacon Health Strategies provided no potential quality issue files. Upon further inquiry by the Department, Beacon Health Strategies confirmed it had no potential quality issue files for the review period.

The Department reviewed the four potential quality issues files provided by the Plan. All four files included documentation showing referral to Beacon Health Strategies. Although the files documented resolution of the enrollee grievances that gave rise to the potential quality issues, there was no documentation provided by the Plan or Beacon Health Strategies demonstrating investigation into the potential quality issues, identification of confirmed issues, effective action to improve care, or follow-up where indicated, as required by Rule 1300.70(a)(1).

Case Files:

File #1 and File #2 involved the same enrollee who called on two separate occasions to complain about not being unable to obtain prescribed medication because it was denied for no authorization on file. The file notes show a grievance and appeals staff member called the provider, the issue was resolved, and an authorization provided. Case notes also document the cases were referred to Beacon Health Strategies. However, there was no evaluation of the quality issue causing the delay or corrective action

[11] PQI files #1, #2, #3 and #4.

implemented to ensure the problem does not happen again. Because the enrollee's need was resolved, the quality case was closed.

File #3 involved a complaint that an enrollee needed assistance finding a new psychiatrist because the enrollee's existing psychiatrist had no appointment availability. The file notes show a quality of access potential quality issue was referred to Beacon Health Strategies. The documentation indicates the enrollee was provided with psychiatry referrals and assistance in obtaining an appointment with a new psychiatrist. Because the enrollee's need was resolved, the quality of access case was closed. However, there was no evaluation of the quality issue, or a determination of whether there was an access problem.

In File #4, an enrollee complained that they contacted the Plan's behavioral health delegate several times to find a provider, but the referrals that were given were for providers not contracted with the delegate. The enrollee expressed significant frustration and a negative impact on their mental health because they had been repeatedly turned away and needed care urgently. Although Beacon Health Strategies documented it had "thoroughly research[ed] the substance of the complaint," its only response was to call the enrollee two months following the complaint to check in. Beacon Health Strategies documented the telephone call and documented its response for the quality care investigation as "NA." There was no investigation into Beacon Health Strategies' referral process or the access issue.

The lack of documented investigation, identification of quality issues, corrective action and necessary follow-up, indicates the Plan is not ensuring its delegate complies with Section 1370 and Rule 1300.70(a)(1).

Conclusion: Potential quality issue files demonstrate the Plan does not ensure quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated as required by Section 1370 and Rule 1300.70(a)(1).

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

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

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

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

#1: <u>The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.</u>

Summary: When asked to provide a copy of the Plan's medical policy to provide Medication Assisted Treatment (MAT), which is delivered in two ways: Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy, the Plan provided a copy of its drug utilization management policy and procedure, a document not responsive to the request. The Plan stated it provides medications that can be used in MAT, dispensed via retail pharmacy. The Plan also stated primary care physicians in its network have become credentialed to be MAT prescribers. However, the Plan acknowledged that increasing the number of such physicians has been a challenge. The Plan has no freestanding OTP facilities in network. Because office-based settings are generally more accessible to enrollees and hold less social stigma as compared to formal treatment program settings, failure to credential or contract with OTPs unnecessarily limits the locations where opioid use disorder treatment can be provided.

#2. <u>Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.</u>

Summary: The Plan and its delegate, Beacon Health Strategies, were asked to produce documents describing how they identify disparities among the Plan's enrollee

population for age, race, culture, ethnicity, sexual orientation, gender identify, income level and geographic location. The Department also requested documents demonstrating activities to monitor and address those disparities, as well as run data reports, and trend summaries used to address and reduce the barriers enrollees face in accessing behavioral health services due to lack of culturally competent services.

The Plan submitted no documents in response. Beacon Health Strategies provided several documents, including three policies and a California-specific Cultural and Linguistic Program Description document that primarily describes access, availability, assessment and resources for language assistance services. [12] The document submission also states Beacon Health Strategies annually administers member satisfaction surveys that, among other things, asks whether counseling or treatment met enrollees' language, communication, religious and cultural needs. However, neither the Plan nor Beacon Health Strategies submitted documents to demonstrate there is a process for identifying, reporting or addressing other cultural disparities as they pertain to the Plan's enrollee population. Specific to the Plan, Beacon Health Strategies provided quarterly work plans for cultural and linguistic reporting, however all reports show consumer satisfaction surveys labeled with "TBD" [to be determined or decided].

The *2019* and *2020 Beacon Population Assessments* presented demographics and population data based on paid claims only, included assessments and data that appeared to be collected, analyzed and reported on a state-wide basis and included aggregated information collected from all other California health plans under contract with Beacon Health Strategies. Therefore, the population assessments did not evaluate or report on Plan enrollees only. Based on information and documents submitted by its delegate, the Plan is unable to evaluate, determine or take steps to address the cultural disparities and needs among its specific enrollee population.

#3: <u>Enrollees experience difficulties obtaining appointments.</u>

Summary: The Department requested the Plan provide data for the review period concerning enrollees who reached out to the Plan or Beacon Health Strategies to request behavioral health appointments or assistance in obtaining behavioral health appointments. The Plan and Beacon Health Strategies responded stating "there is no data for the requested time period." The Plan noted, however, customer service calls include requests for assistance in finding a provider. The Department reviewed enrollee inquiry data submitted by Beacon Health Strategies, comprised of 322 entries, including 21 enrollees who called three or more times to request assistance with identifying a behavioral health provider or obtaining behavioral health services.

[12] The submitted documents included Policy QM33.10 *Cultural and Linguistic Competency and Health Literacy Program*; Policy QM 33A *Cultural and Linguistic Competency and Health Literacy Program – California Specific*; and *Policy QM 34.10 Analysis of Covered Populations*. Beacon Health Strategies also provided *Cultural and Linguistic Program Descriptions* and CA Addenda for years 2020, 2021, 2022.

Based on review of inquiry data provided by Beacon Health Strategies,[13] the Department identified the following issues indicating enrollees experienced delays and difficulties obtaining behavioral health services:

1. Enrollees called Beacon Health Strategies several times for assistance in obtaining a behavioral health appointment, but Beacon Health Strategies' claims information indicates either a delay in services provided to the enrollee, or no claim at all, indicating either the enrollee was unable to obtain services, or they obtained services from an out-of-network provider for which the enrollee paid out of pocket.

   Example A: An enrollee called Beacon Health Strategies seven times between February and April 2021, seeking information, assistance and referrals for services related to substance use disorder treatment.[14] During one call, the customer service representative attempted to transfer the enrollee's call to a clinician, but noted there was no answer after a 10-minute wait. The enrollee hung up or disconnected during three of the calls. The sixth call involved a customer service representative calling the enrollee's parent to state Beacon Health Strategies did not have the "member's ID or account information" although the previous calls from the enrollee noted the enrollee's member eligibility had been verified. During the final call, customer service notes state the enrollee's call was transferred to a case manager. There were no claims submitted for services provided to this enrollee indicating no services were rendered through the delegate.

   Example B: An enrollee called Beacon Health Strategies three times in 10 days.[15] During the first call, the customer service representative tried to transfer the enrollee's call to a service coordinator, but noted none were available and a "call-back" was created. The enrollee was to receive a call back from Beacon Health Strategies for assistance. The following afternoon, the enrollee called to say they did not receive a call back. The customer service representative documented that they explained how the process works when Beacon Health Strategies assists enrollees with appointments (termed "Routine With Assistance" or RWA). During the process, Beacon Health Strategies takes up to five days to find an appointment/provider. The enrollee called a final time, nine days later, stating the enrollee was offered a referral to a provider that does not provide medication management. The customer service representative documented the RWA "is closed out because it has been so long." The enrollee did not receive services until a month later.[16]

   Example C: An enrollee called Beacon Health Strategies seven times between January and April 2021 seeking assistance in obtaining psychiatry services.[17]

[13] Beacon Health Strategies Log C.
[14] Log C Plan File ID #s 332507426, 357789488, 357794113, 360845147, 360861343, 360865777, 361022326.
[15] Log C Plan File ID #s 345718833, 345823710, 346223458.
[16] Log H Claim #s 154573669 and 161784979.
[17] Log C Plan File ID #s 329132121, 329132367, 332960827, 333911847, 335837561, 338128853, 338147713.

Initially, the enrollee asked for the Beacon Health Strategies' website to independently search for providers. Two months later, in March 2021, the enrollee called back to request a referral. Two days later the enrollee called Beacon Health Strategies again, stating someone was supposed to email them with "some referrals" but they received nothing. The customer service representative checked previous notes and found no email address for the enrollee, so they documented the enrollee's email address and sent the names of four providers to the enrollee. A week later the enrollee called to say the list of referrals was never received. The customer service representative documented verbally giving the enrollee the names and contact information for the four providers. The following month, in April 2021, the enrollee called to state they were given referrals and they "did not work." The customer service representative offered RWA appointment assistance, which the enrollee accepted. However, no service coordinator was available at the time, so the need for a call-back was documented by the customer service representative. Claims data shows the only services provided in 2021 for which a claim was submitted occurred in August 2021.[18]

Example D: An enrollee called Beacon Health Strategies in October 2021 seeking assistance in obtaining therapy services. The customer service representative documented offering the enrollee telehealth services, which the enrollee declined. The customer service representative provided the enrollee with the names of three providers.[19] In January 2022, the enrollee called back, seeking RWA appointment assistance for both therapy and psychiatry. [20] The customer service representative again offered telehealth services, which the enrollee declined. The customer service representative noted advising the enrollee "we will outreach for up to 5 days" and provided the Beacon Health Strategies' website for self-referrals. Claims data indicates no services were provided in 2021 and telehealth services, which the enrollee twice declined, were provided in April and May 2022, three and four months after the enrollee's request for appointment assistance.[21]

2. Other enrollee calls indicating enrollees experienced barriers in obtaining behavioral health services include:

   - Enrollees stated providers required or refused to make appointments for behavioral health services without first getting registration or authorization numbers, when such information was not required. [22]

[18] Log H Claim #152559219
[19] Log C Plan File ID #350406946
[20] Log C Plan File ID #356763040
[21] Log H Claim #s 160736059, 161226594, 161735173.
[22] Log C Plan File ID #s: 357016960, 356034494, 356055572, 306982399, 308152309

- Customer service representatives providing inaccurate information or lack understanding of the enrollee's behavioral health coverage or behavioral health processes. For example, customer service representatives informed enrollees that Beacon Health Strategies does not manage certain behavioral health services, and those services are managed by the Plan. However, the customer service representative discovered they were incorrect.[23]
- Enrollees called Beacon Health Strategies back for additional referrals stating previously received referrals didn't work out, provider phone numbers were incorrect, providers did not answer or were not taking new patients, or a "more accurate" list was requested than what was available on Beacon Health Strategies' website.[24]
- Disconnected phone calls occurred 13 times among the 322 entries (4%), suggesting some enrollees either become frustrated and hang up mid-call or there are phone system issues.

The issues described above demonstrate enrollees experienced a variety of barriers, delays and difficulties in obtaining behavioral health services, and claims data showed some enrollees either never obtained services or obtained out-of-network services for which they paid out of pocket.

[23] Log C Plan File ID #s 336451662, 311845369
[24] Log C Plan File ID #s 338147713, 321089475, 342335020, 348484177

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified two Knox-Keene Act violations and three barriers to care not based on Knox-Keene Act requirements.

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

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

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

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

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

The Plan must submit its Response, if any, and CAP via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**. Once logged in, follow the steps shown below to view and submit the documents required:

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

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP and any Barriers Statement submitted by the Plan, will be posted to the Department's website.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

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

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: ALAMEDA ALLIANCE FOR HEALTH	
Scott Coffin	Chief Executive Officer
Steve O'Brien, MD	Chief Medical Officer
Matthew Woodruff	Chief Operating Officer
Richard Golfin III	Chief Compliance Officer & Chief Privacy Officer
Tiffany Cheang	Chief Analytics Officer
Sasikumar Karaiyan	Chief Information Officer & Chief Security Officer
Gil Riojas	Chief Financial Officer
Anastacia Swift	Chief Human Resource Officer
Ruth Watson	Chief Projects Officer
Sanjay Bhatt, MD	Senior Medical Director
Peter Currie, PhD	Senior Director, Behavioral Health
Rosalia Mendoza, MD	Utilization Management, Medical Director
Helen Lee	PharmD, Senior Director, Pharmacy Service
Julie Anne Miller	Senior Director, Health Care Services
Gia DeGrano	Senior. Director, Member Services
Mark DaShiell	Senior. Director, Quality Improvement
Paul Touris	Director, Claims
Darryl Crowder	Director, Provider Services
Elizabeth Olsen-Lennon	Director, Vendor Management
Lily Hunter	Director, Social Determinants of Health
Julia Kim	Senior Manager, Analytics
Donna Ceccanti	Senior Manager, Peer Review & Credentialing
Michelle Lewis	Senior Manager, Communications & Outreach
Hope Desrochers, RN	Manager, Outpatient UM
Carla Healy-London, RN	Manager, Inpatient UM
Linda Ayala	Manager, Health Education
Kisha Gerena	Manager, Grievance and Appeals
Judy Rosas	Manager, Member Services
Monica Cabral	Manager, Claims Operations Support
Cecilia Gomez	Manager, Provider Services
Loc Tran	Manager, Access to Care
Farashta Zainal	Manager, Quality Improvement
Christine Rattray	Supervisor, Quality Improvement
Rahel Negash	Lead Clinical Pharmacist
Benita Ochoa	Lead Pharmacy Technician
Ramon Tran Tang	Clinical Pharmacist
Vanessa Suarez	Strategic Account Representative

PLAN STAFF INTERVIEWED FROM: ALAMEDA ALLIANCE FOR HEALTH (continued)	
Eileen Ahn	Specialist, Accreditation and Regulatory Compliance, G&A
Carlos Lopez	Sr. Quality Assurance & Reporting Analyst, Member Services
Jennifer Vo	Associate Counsel
Katherine Goodwin	Compliance Auditor
Jill Drake	Regulatory Compliance Specialist
Dana Johnson	BH CM Nurse
Dennis Mullenix, LMFT	BH Triage Specialist
Michaela Thompson, LCSW	BH Triage Specialist
Hermine Voskanyan, BCBA	ABA Analyst
Monica Valle	MSR III Bilingual Spanish
Tina Vuu	QA Specialist Bilingual Vietnamese
DELEGATE STAFF INTERVIEWED FROM: PerformRx	
Dan Gustafson	Manager Pharmacy Prior Auth
Patrick Guan	Regional Account Executive
Barrie Cheung	Regional Pharmacy Director
Avelina Leal	Director of Pharmacy Service Operations
Patrick McCann	Business Analyst PRx Pharmacy Service Operations
Ben Gonzalez, CPhT	Pharmacy Benefit Claims Analyst
Natalee Felten	Pharmacist II Clinical Services
Jenna Heath	Supervisor Formulary/DUR, Pharmacy Clinical Services
Christine Payne	Pharmacy Resident, Pharmacy Clinical Services
Noel Ortiz	Director Clinical Operations Rx, Clinical Operations
Paul Fagan	Manager SD Pharmacy Benefits, Clinical Operations
Ben Gonzalez	Claims Analyst, Clinical Operations
Emily Yang	Director Compliance PRX, Pharmacy Compliance & Quality
DELEGATE STAFF INTERVIEWED FROM: BEACON	
Alison French	Account Executive II
Jenny Hua	Business Analyst II
Kaneisha Jeffreys	AVP of Operations
Brandy Gadino	AVP of Regional Quality
Shawna Gibson	Quality Internal Audit Specialist
Gary Proctor, MD	Medical Director
Craig Wronski, MD	Medical Director
Mandy Kullar	Director of BH Clinical Services (Outpatient)
Katy Susienka	Director of BH Clinical Services (Inpatient)
Torrey Daniels	BH Clinical Quality Audit Analyst Sr
Jenifer McAtee	Director of BH Clinical Services (Case Management)

DELEGATE STAFF INTERVIEWED FROM: BEACON (continued)	
Sharon Gollaher	Director of BH Clinical Services (Case Management)
Irma Flores	Manager of Customer Care
Jason Jarrett	Director of Service Operations
Anthony Holston	AVP of Grievance & Appeals
Lourdes Basmajian	Director of Grievance & Appeals
Shannon Trammell	Director of Grievance & Appeals
Laurel Fox	BH Clinical Quality Audit Analyst Sr
Bonnie Eng	Director of Contracting
Samuel Bradley	Network Contract Administrator
Danielle Hafner	Network Services Assistant
Nicole Nole	Director of Network Development
Amy Daversa	Director of Systems Support & Program
Laura Grigoruk	Director of Provider Relations
Joshua Quinn	Manager of Claims
Christina Rosa	Director of Claims
Edward Vivero	Manager of Grievance & Appeals (PDR)

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management - Rx	30	6660171 6693576 6845246 6847764 6870237 6883741 6890589 6917187 6980397 6985421 7021342 7032332 7130701 7132512 7149209 7158561 7187776 7194573 7230563 7233116 7235698 7288460 7288626 7375413 7375413 7598077 7646971 7729550 7823598 7847712

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management	15	22266995 22269276 22274123 22276622 22311446 22813049 22937336 22943395 22959364 23022165 23036804 23058232 23193021 23207324 23208141
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Benefit/Coverage/ Experimental/ Administrative Denials - Rx	5	6902139 7223915 7625858 7728617 22153331
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Inquires	30	730125-0 865798-1 667146-0 701062-0 621804-0 684933-1 661824-0 783199-1 767410-0 800784-0 778589-0 661992-0 760816-0 781976-0 711311-0 656158-0 820092-0 871152-0 896692-0 664623-0

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Inquires (continued)		699376-0 684933-0 804109-0 802698-0 750556-0 872909-0 665186-0 667878-0 707494-0 656733-0
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Inquires - Beacon	31	319605466 357618043 327858911 346386643 346812397 314865900 337777433 331058841 317205436 310236955 360890237 316605765 360547303 332125105 357643876 356034494 312773356 342532405 321454540 321289197 361020527 360865777 321866042 321328355 340484712 336524471 339640010 342317642 340117004 336451662 339922736

Type of Case Files Reviewed	# of Files	Case ID Number
Provider Complaints - Plan	2	11093776 11296257
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Provider Complaints - Beacon	2	8189 11133
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievances and Appeals	24	813850-32781 800801-30582 700220-14365 749989-22175 749989-24419 749989-24420 684780-9511 730229-19040 886111-41558 719593-17364 775147-26361 718338-17192 707931-15527 654386-4146 655451-4322 669765-6939 739199-20466 744248-21307 745891-21548 778495-26798 783165-27549 820144-33828 823959-34490 839918-37108
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issue	4	749989 753397 778495 820144
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Out of Network Requests	3	22153331 2215978 22147053

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims (Plan)	30	905601721 129318523 893404844 837298312 100480469 275634773 803103462 992418217 103201636 573806444 404457159 959198547 992418217 339810317 84950408 557662321 20824605 56953901 732223555 752817756 328199626 610831519 717446836 458454443 275557251 411365744 275557251 494409044 494419003 879968607
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Denied Claims (Beacon)	30	155580115 134308057 162428419 157290273 162953793 139089509 132596588 142548902 154627887 162546502 148210367 134104391

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims (Beacon) [continued]		144838821 155642919 134244255 154609440 160980225 143871282 159927550 149682601 161953178 134244266 155936778 157748537 155582519 148661304 133107440 158549109 154128006 161599985
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Paid Claims (Plan)	31	537170804 758205335 660032420 953365441 520082688 141446737 225557405 762736369 756841888 444722444 643261513 394756491 546122331 310808888 848919856 357379425 109940825 660032420 105033525 655452105 677921828 188360116 812936515 57070223 492093897

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims (Plan) [continued]		537170804 310943774 982318707 503700742 72122267 748289313
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Paid Claims (Beacon)	30	162462707 159434148 156217821 134440409 156926208 161022540 162626408 131185554 149786844 151524136 157894969 157895079 159613711 159434148 133466741 161584355 139720925 155636120 157895062 157894954 142723739 149900500 156265336 132432399 149335259 153869412 144104322 160592651 146272232 157704386

Alameda Alliance For Health
Corrective Action Plan Response

Alameda Alliance for Health

Corrective Action Plan Responses to DMHC Behavioral Health Investigation Report

Review/Audit Type: 2022 DMHC BHI Survey **Review Period:** April 1, 2020 through April 30, 2022

Deficiency Number & Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date
UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING			
1. The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855) Statutory/Regulatory Reference(s): Sections 1374.72 and 1374.721	Alameda Alliance for Health (Alliance) reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, the Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making.	Updated P&P and Program Description provided in 2022, also attached.	**WPATH training:** - 100% of current UM reviewers will complete WPATH Training by Q2 2024 - 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date **Annual IRR**: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024

Deficiency Number & Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date
	The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met.		
QUALITY ASSURANCE			
2. The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(1)	As of April 1, 2023, Alameda Alliance for Health (AAH) has terminated its contract with Beacon Health Options. Since termination, the Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	DMHC Order of Approval Order & Transmittal Recognizing the Plans Terminated Relationship with the MBHO, Beacon Health Options	April 1, 2023

Submitted by:
Richard Golfin III, FACHE | Chief Compliance & Privacy Officer

Submission Date: 01/29/2024

Principal Officer's signature:

DocuSigned by:
Matthew Woodruff
B72F5D300D044D8...

Matthew Woodruff, Chief Executive Officer