DEPARTMENT OF Managed Health Care

BEHAVIORAL HEALTH INVESTIGATIONS

Phase Two Summary Report

June 2024

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Table of Contents

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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 under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets.

The Department is conducting behavioral health investigations (BHIs) of all full-service commercial health plans regulated by the Department, with the intent to investigate an average of five health plans per year. The purpose of the BHIs is to understand the challenges enrollees are experiencing accessing behavioral health services. By focusing on health plan operations specific to behavioral health care and exploring the enrollee and provider experience, the Department identified violations of law as well as other barriers experienced by enrollees when obtaining, and experienced by providers in delivering, medically necessary behavioral health care services. The investigations are separate from the Department's routine medical surveys, or audits, which are conducted every three years.

This Phase Two Summary Report includes a list of the Knox-Keene Act violations that were identified for each of the investigated health plans,[1] and provides a summary of other barriers to care. Barriers to care may include health plan practices, policies, operations, or other activities that may not rise to a violation of the law, but may contribute to challenges, delays or obstacles faced by enrollees as they navigate the health plan's system to access behavioral health services. Barriers can negatively impact enrollees' ability to obtain behavioral health care.

Key Knox-Keene Act Violation Findings:

- Three health plans had at least one quality assurance violation. These violations may result in health plans or their delegated entities not identifying and/or investigating quality of care issues.
- Two health plans had at least one grievance and appeals violation, resulting in failure to provide required information to enrollees who submit urgent grievances, failure to identify all grievances, and/or failure to track and monitor grievances.
- One health plan had a utilization management violation, resulting in failure to timely implement required clinical criteria and make needed policy revisions.
- One health plan had a pharmacy violation, resulting in delayed decisions and notifications regarding formulary exception requests.
- One health plan had a violation related to after-hours accessibility, which may result in enrollees not receiving information pertaining to after-hours care.
- One health plan had a claims payment violation, resulting in denial of a claim for previously authorized services.

[1] A full description of each Knox-Keene Act violation can be viewed in the health plans' individual BHI reports, available on the Department's website.

Key Barrier Findings:

- Two health plans were unable to demonstrate they cover office based opioid treatment and opioid treatment program therapy services. Current law requires coverage of these treatments but is not specific regarding the setting. However, without offering these office-based services, enrollees are limited in where they can obtain opioid treatment.
- One health plan and its behavioral health delegate do not conduct assessments pertaining to cultural competency and health equity specific to the Plan's population.
- Two health plans lack a comprehensive plan to identify and address disparities across the plans' enrollee populations due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location.
- One health plan's behavioral health delegate uses a customer service system that does not track repeat callers.
- One health plan's behavioral health delegate does not identify, track and report behavioral health services that are disproportionately denied.
- Three health plans provided data demonstrating enrollees experienced delays when calling the plan, or limited access to substance use disorder facilities, or faced difficulties when trying to secure behavioral health appointments.
- One health plan's provider survey results demonstrated contracted providers are increasingly dissatisfied with network access.

The health plans were required to submit corrective action plans (CAPs) to correct each Knox-Keene Act violation identified in the respective health plan's BHI Report. The health plans were also provided an opportunity to submit a separate written response to the barriers identified in each health plan's respective report, describing any steps taken or to be taken to address the barriers (Barriers Statement). The individual BHI Report for each of the health plans, along with each health plan's corrective action plan to address the Knox-Keene Act violations in the plan's report, and any Barriers Statement, can be found on the Department's Website. The Knox-Keene Act violations noted in the BHI Reports, along with corrective action plans, will be referred to the Department's Office of Enforcement to evaluate and take appropriate enforcement actions, which may include corrective actions and administrative penalties. For the barriers not related to Knox-Keene Act violations, the Department provided recommendations to assist health plans in considering ways to address barriers and improve access to timely, appropriate behavioral health care for all enrollees. The barriers, recommendations and health plan actions may serve to inform future statutory and/or regulatory changes.

INTRODUCTION AND BACKGROUND

The Department utilizes a variety of regulatory tools to assess whether enrollees are able to obtain timely access to behavioral health care services, including routine medical surveys, federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) focused surveys, annual review of health plan provider networks, reviewing health plan annual timely access compliance reports, and tracking and trending enrollee complaints and independent medical review applications to identify enrollee complaint patterns from year to year.

Effective January 1, 2021, health plans are required to cover medically necessary treatment of all behavioral health conditions recognized by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, regardless of age or product type, as required by Senate Bill (SB) 855 (Wiener, 2020). In addition, SB 855 established a statutory definition of "medically necessary treatment" for purposes of mental health and substance use disorder treatment and requires plans to use the clinical criteria developed by non-profit associations for the relevant clinical specialty. The Department issued guidance to the plans requiring them to demonstrate compliance with SB 855 and has promulgated regulations which took effect on April 1, 2024, related to the implementation of SB 855. The Department will monitor compliance with these requirements through the routine medical survey process.

In addition, beginning July 1, 2022, health plans are required to ensure that their contracted provider networks can offer non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment, or longer if the treating provider determines a longer wait time will not have a detrimental impact on the health of the enrollee, as required by SB 221 (Wiener, 2021). SB 221 also requires health plans to arrange coverage outside of the plan's contracted network if medically necessary treatment of a mental health or substance use disorder is not timely available with an in-network provider. The Department has incorporated these requirements into the annual timely access filing and annual review of provider networks. In addition, the Department will monitor compliance through the routine medical survey process.[2]

Notwithstanding this rigorous oversight of access to behavioral health care services, many enrollees continue to experience difficulty accessing timely behavioral health care services. Based on stakeholder feedback as well as complaints to the DMHC's Help Center, enrollees often experience challenges finding in-network providers that are accepting new patients and scheduling timely initial and follow-up appointments. Even when an enrollee successfully connects with a provider, the enrollee may face additional obstacles in obtaining care due to health plan or health plan delegate's clinical guidelines that may limit or delay initial authorizations, treatment durations or covered services. As a result, many enrollees abandon their efforts to seek in-network care and may subsequently pay out-of-pocket for behavioral health care services with an out-of-network provider, seek costly care in hospital emergency rooms or county inpatient centers, or may not obtain medically necessary behavioral health care. The BHIs include assessment of the health plans' behavioral health delivery system, including the operations of any behavioral health delegate, with a focus on the enrollee experience. [3]

The full-service commercial health plans subject to the BHIs are investigated in phases. The Department selected the plans based on enrollment size, counties of operation,

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[2] The review periods for the health plans' BHIs were April 1, 2020 through March 31, 2022 (Western Health Advantage), April 1, 2020 through April 30, 2022 (Alameda Alliance For Health), April 1, 2020 through May 31, 2022 (Sharp Health Plan), and April 1, 2020 through June 30, 2022 (Anthem Blue Cross), prior to implementation requirements of SB 221. Therefore, the health plans' compliance with SB 221 requirements were not evaluated as part of their BHI, but will be assessed through the Department's routine medical survey process.

[3] 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.

and how the plan provides behavioral health services to their enrollees, such as the use of a specialized behavioral health plan. In addition, the Department sought to avoid scheduling the investigations near or during a Department routine medical survey. This Phase Two Summary BHI Report describes the findings of the following health plans:

- Western Health Advantage
- Alameda Alliance For Health
- Sharp Health Plan
- Anthem Blue Cross of California

The DMHC originally planned to conduct a BHI of Kaiser Foundation Health Plan, Inc. (Kaiser Permanente) during Phase Two. However, following a significant enforcement action taken in 2023 requiring the plan to make transformative changes to its delivery of behavioral health care services, the Department decided it would be more meaningful to conduct a BHI of this plan after it has had an opportunity to implement some of the corrective actions expected in connection with the enforcement action.

METHODS

To evaluate health plan operations, the Department requested and reviewed documents, files and data of the health plan and any behavioral health and/or pharmacy delegates. The Department also conducted interviews with health plans and delegates.

To further understand potential barriers to care from the perspective of enrollees and providers, the Department separately interviewed enrollees and providers about their experiences with the health plans.

The BHIs 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

SUMMARY OF KNOX-KEENE ACT VIOLATIONS

The Department identified 10 separate Knox-Keene Act violations that, in some instances, applied to multiple health plans.

	Knox-Keene Act Violations	Health Plans
Appointment Availability and Timely Access		
1	Failure to ensure after-hours emergent and urgent information was provided to all enrollees. Additionally, the plan is operating at variance with filed policies and procedures. Rule 1300.67.2.2 (c)(8)(B)(1)	• Sharp Health Plan
Utilization Management, including Triage and Screening		
2	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855).	• Alameda Alliance For Health
Pharmacy		
3	The Plan does not make its determinations on formulary exception requests and provide notification to enrollee, enrollee's delegate or prescriber on a timely basis. Section 1367.24(k); 45 C.F.R. 156.122(c)(3)(ii)	• Anthem Blue Cross
Quality Assurance		
4	The Plan failed to perform oversight of its behavioral health providers to ensure triage and screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage and screening waiting time does not exceed 30 minutes. Rules 1300.67.2.2(c)(8)(A), (B)	• Sharp Health Plan
5	Failure of the health plan [or its delegate] to consistently document quality of care provided is being reviewed, problems are being identified and/or ensure effective action is taken to improve care where violations are identified, and follow-up is planned where indicated. Rules 1300.70(a)(1), 1300.70(a)(1), 1300.70(b)(1)(A), (B)	• Alameda Alliance For Health • Anthem Blue Cross • Sharp Health Plan
6	The Plan failed to document follow-up when quality of care issues were identified. Section 1370; Rule 1300.70(a)(1) and 1300.70(b)(1)(A) and (B)	• Sharp Health Plan

Grievances and Appeals		
7	The Plan does not consistently provide immediate notification to grievants of the right to contact the Department about expedited grievances. Section 1368.01(b) and Rule 1300.68.01(a)(1)	• Anthem Blue Cross
8	Failure to maintain the required log of exempt grievances and failure to demonstrate periodic review of the log of exempt grievance data. Rule 1300.68(d)(8)	• Anthem Blue Cross • Sharp Health Plan
9	The Plan's customer service representatives failed to identify all grievances. Rules 1300.68(a)(1), (a)(2)	• Sharp Health Plan
Claims Submission and Payment		
10	The Plan failed to pay a claim for previously authorized services. Section 1371.8	• Western Health Advantage

OTHER BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS & RECOMMENDATIONS FOR IMPROVEMENT

The Department identified seven barriers to care among the four health plans reviewed in this phase. Several of the barriers apply to multiple health plans. Each barrier is described in detail below.

Pharmacy

1. **Health Plans have limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and/or lack policies and procedures for these treatments.**

Impacted Health Plans: Alameda Alliance For Health, Sharp Health Plan

Office Based Opioid Treatment (OBOT) involves a specially credentialed physician prescribing certain drugs to prevent opioid withdrawal and reduce cravings for opioid drugs (opioid agonist medications) during routine office visits. It does not include counseling. Opioid Treatment Programs (OTPs) provide more intensive treatment with prescribed medication and other forms of therapy, including individual and group counseling. OTPs must obtain certification and accreditation through a process administered by the federal Substance Abuse and Mental Health Services Administration and meet other federal requirements.[4] Providing OBOT and OTP services in office-based settings offer greater accessibility to enrollees and hold less social stigma as compared to formal treatment program settings.

Two of the plans, Alameda Alliance For Health and Sharp Health Plan, acknowledged they have no policies and procedures related to Medication Assisted Treatment (MAT)

[4] 45 C.F.R. 156.122(c)(1)-(3).

that include OBOT and OTP. Both plans also described experiencing difficulties getting contracted primary care physicians credentialed to administer MAT such as OBOT and OTP.

Health plans that do not have policies and procedures for OBOT and OTP and/or offer limited access to these services impede enrollees' ability to obtain opioid use disorder treatment in office-based settings.

Recommendations and Other Considerations

As applicable, health plans should evaluate whether to conduct medical management for OBOT and OTP in the first instance in order to improve access to opioid use disorder treatment. For health plans that continue to conduct medical management, they should develop and implement policies and procedures pertaining to OBOT and OTP, and expand access to telehealth services when appropriate.

Cultural Competency, Health Equity and Language Assistance

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>.

Impacted Health Plan: Alameda Alliance For Health

Health plans may conduct a cultural competency and health equity assessment as it pertains to the health plan's enrollees, including for example, identifying disparities among the plan's enrollee population for age, race, culture, ethnicity, sexual orientation, gender identify, income level and geographic location. This assessment can improve health outcomes and reduce or eliminate disparities by understanding the challenges faced by enrollees.

Alameda Alliance For Health provided no documents to demonstrate it identifies, monitors, or addresses these types of disparities among its enrollee population. The Plan's behavioral health delegate, Beacon Health Strategies, aggregates and reports demographic and population data on a statewide basis, but was unable to demonstrate it assesses or addresses cultural or health disparities specific to the Plan.

Recommendations and Other Considerations

The Plan is encouraged to work with its behavioral health delegate to develop strategies and methods for assessing, identifying, reporting, and addressing cultural and health disparities as they pertain to the Plan's enrollee population.

3. <u>Health Plans lack a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location</u>.

Impacted Health Plans: Sharp Health Plan, Western Health Advantage

Studies suggest that lack of cultural competency in the health care setting can result in adverse patient safety events.[5] Health care services rendered without consideration of cultural and linguistic needs and circumstances may result in diagnostics errors, unexpected negative responses to medication, harmful treatment interactions from simultaneous use of traditional medicines, inappropriate care transitions, and inadequate patient adherence to provider recommendations and follow-up visits.[6]

Additionally, there are indications showing racial minorities are less likely to have adequate access, seek help and have their mental health disorders diagnosed.[7] LGBTQ populations experience higher rates of mental disorders such as anxiety and depression, have higher rates of suicidal ideation and are subject to more emotional, physical and sexual trauma than straight and cisgender people.[8]

At a minimum, health plans are required to have a language assistance program that assesses the plan's enrollee population to develop a demographic profile and survey the linguistic needs of enrollees.[9] Additionally, plans must provide training regarding the language assistance program to plan staff who have routine contact with limited English proficient enrollees.[10] However, cultural competency is broader and encompasses more than language. Two of the health plans in phase two, Sharp Health Plan and Western Health Advantage, lacked sufficient processes, procedures, policies, and operations necessary to identify and address cultural disparities in the health plans' commercial enrollee population.

Recommendations and Other Considerations

Health plans and behavioral health delegates should develop and implement comprehensive and effective programs for staff and participating providers to ensure behavioral health services are provided in a culturally competent manner that address the needs of the enrollee population. These programs should ensure adequate training is provided, monitored and documented. Plans and behavioral health delegates should also evaluate and document implementation of the strategies, methods, and requirements stated in their policies and procedures related to cultural and linguistic competency and assess the effectiveness and impact of implementation on enrollees and providers to further develop and improve their cultural competency practices.

Grievances and Appeals

4. <u>Grievance system lacks the ability to track repeat callers</u>.

Impacted Health Plan: Western Health Advantage

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[5] Brach et al., *Cultural Competency and Patient Safety* (December 27, 2019) <https://psnet.ahrq.gov/perspective/cultural-competence-and-patient-safety#> (as of January 10, 2024).
[6] *Id.*
[7] Rice & Harris, *Issues of cultural competence in mental health care* (October 2020) Journal of the American Pharmacists Association <https://www.japha.org/action/showPdf?pii=S1544-3191%2820%2930530-6> (as of January 10, 2024).
[8] Butler et al., Improving Cultural Competence to Reduce Health Disparities (2016) <https://www.ncbi.nlm.nih.gov/books/NBK361118/> (as of January 10, 2024).
[9] Rule 1300.67.04(c)(1).
[10] Rule 1300.67.04(c)(3)(D).

A health plan's grievance system that has the ability to track and analyze repeat calls from enrollees permits the plan to identify a range of issues ranging from customer service problems to quality of care issues. Additionally, repeat caller data can provide a health plan with information about how well the plan is meeting enrollee needs.

Western Health Advantage's behavioral health delegate, Human Affairs International (HAI-CA) uses a proprietary system for documenting phone calls from enrollees. The system does not generate a report identifying and tracking instances in which a caller makes more than one call in order to resolve a concern ("repeat callers"). Western Health Advantage also has no system to identify repeat callers. As a result, Western Health Advantage and HAI-CA lack the ability to fully evaluate this meaningful enrollee data and use it to improve the provision of behavioral health services and customer service.

Recommendations and Other Considerations

The Plan is encouraged to develop and implement a system to identify and track repeat callers and related data to improve its ability to identify trends, increase the effectiveness of customer service operations, and enhance enrollees' ability to obtain appropriate, timely behavioral health services.

5. <u>One health plan does not identify, track and report behavioral health services with a high denial rate</u>.

Impacted Health Plan: Western Health Advantage

As Western Health Advantage's behavioral health delegate, HAI-CA is responsible for handling grievances and appeals pertaining to behavioral health services. Grievance and appeals data submitted by HAI-CA for the BHI review period showed that 45% of all urgent appeals involved denials for services to treat alcohol dependence. In 81% of those denial instances, the decision to deny care was upheld on appeal. Neither HAI-CA nor Western Health Advantage have a process to track behavioral health services subject to high denial rates. HAI-CA's failure to identify and report high rates of denial information to the Plan prevents the Plan from being able to track, trend or address issues involving these specific services or understanding the experiences of its enrollees seeking behavioral health care.

Recommendations and Other Considerations

To ensure the Plan is providing enrollees with appropriate and timely behavioral health care, the Plan should consider developing and implementing processes to identify and track services incurring high denial rates and evaluate and address the reasons for the high denial rate.

Enrollee and Provider Experience

6. <u>Enrollee telephone calls and experience surveys indicate enrollees experience difficulties in obtaining behavioral health services.</u>

Impacted Plans: Alameda Alliance For Health, Sharp Health Plan, Western Health Advantage

Health plans collect enrollee data from various sources. The data can be used to evaluate enrollee needs and areas in which the health plan could implement improvements. Enrollee telephone calls to health plans, or their behavioral health delegate, are one direct source of information from which enrollee needs, perspectives and complaints may be obtained. Enrollee telephone calls to three health plans, or their behavioral health delegate, demonstrated the plans' enrollees experienced delays and difficulties obtaining behavioral health services.

Data from enrollee calls to Alameda Alliance For Health's behavioral health delegate Beacon Health Strategies demonstrated enrollees experienced delays in obtaining assistance to secure behavioral health services because of Beacon Health Strategies' internal processes, provider misinformation about prior authorization requirements, and problems with lists of providers given to enrollees.

Data from enrollee calls to Western Health Advantage's behavioral health delegate HAI-CA demonstrated enrollees attempted unsuccessfully to contact providers and secure appointments. In some cases, providers were not accepting new patients, did not return the enrollee's phone call or did not have the specific experience needed. In other cases, HAI-CA efforts to conduct appointment searches for enrollees led to delays because HAI-CA was not, from the enrollee's perspective, securing appointments in a timely manner.

Surveying enrollees is another way health plans can collect information from enrollees and gauge not only satisfaction with the health plan and/or the provided services, but also assess the effectiveness of the health plan in providing services.

Enrollees who responded to Sharp Health Plan's 2021 enrollee survey did not give high satisfaction ratings in three areas:

- Ease of getting the treatment you thought you needed,
- Satisfaction with the range of available services, and
- Ease of getting [a provider] you are happy with.

Requests from enrollees to receive behavioral health services from an out-of-network provider further demonstrated enrollees faced challenges obtaining services from contracted providers, requiring them to seek out-of-network care. Additionally, telephone calls to the Plan, identified by the Sharp Health Plan as "inquiries," included expressions of frustration and difficulty in getting behavioral health appointments, negative experiences with the Plan or providers, receipt of unexpected bills or other complaints.

Recommendations and Other Considerations

Health plans should consider whether enrollee experience ratings and degree of satisfaction impact the Plan's enrollment and quality of service. Enrollees have choices about which health plans they want to do business with and prior experience with the health plan may play a significant role in that choice.

Health plans are encouraged to evaluate experience and satisfaction ratings to identify trends and develop and implement strategies to improve both the enrollee experience and enrollee satisfaction.

7. Providers are increasingly dissatisfied with network access.

Impacted Plan: Western Health Advantage

Provider experience surveys furnish health plans with information about how their contracted providers perceive health plan operations. This critical information allows health plans to identify areas of dissatisfaction and develop ways to address those areas and any shortcomings. Because providers are the direct link to patient care, understanding and addressing provider concerns may directly impact the quality of care delivered to enrollees.

Western Health Advantage's behavioral health delegate, HAI-CA conducted an annual provider survey to solicit from physician and non-physician mental health providers their concerns regarding enrollee access to care. HAI-CA reported the results of its 2021 provider survey, which showed a decrease in satisfaction for the metric "Access to care from providers in the network for your clients/patients in the timeframe you determined necessary" from 71.8% in 2020 to 67.7% in 2021. Additionally, more than 30% of providers were "dissatisfied" or "very dissatisfied" with enrollee wait times for behavioral health appointments. Finally, for the metric "ease of referral" of enrollees to other providers, the satisfaction rating of "satisfied" or "highly satisfied" decreased from 72.9% to 56.2% from 2020 to 2021.

Recommendations and Other Considerations

Internal health plan survey data provide health plans with a wealth of information. Health plans should consider tracking and trending survey response data, developing and implementing strategies to address shortfalls or declining satisfaction, and ensure follow-up is conducted to evaluate the effectiveness of the plan's response. Development of response strategies would benefit from provider involvement and recommendations.

CONCLUSION

The Department identified 10 separate Knox-Keene Act violations that in some instances, applied to multiple health plans. Additionally, through document review, interviews with the health plans and their delegates, as well as interviews with enrollees and providers, the Department identified seven separate barriers to care, several of which were identified as applying to multiple health plans.

All Knox-Keene Act violations will be referred to the Department's Office of Enforcement along with corrective action plans submitted by each health plan for their respective violations.

The identified violations and barriers to care impede enrollees' ability to obtain behavioral health services. Health plans are responsible to establish operations,

processes and procedures and business models that assist enrollees rather than hinder their access to care. Additionally, the results of the BHIs demonstrate that behavioral health providers experience barriers in attempting to provide timely and appropriate care. Health plans must make necessary changes to improve access to needed behavioral health care for all Californians.