DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

SUTTER HEALTH PLAN
DBA SUTTER HEALTH PLUS

August 31, 2023

Behavioral Health Investigation
Sutter Health Plus
August 31, 2023

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 received approval from the 2020-21 state budget to conduct 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 Sutter Health Plus (Plan) is included in Phase One.

On April 16, 2021, the Department notified the Plan of its BHI covering the time period of April 1, 2019, through March 31, 2021. 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, U.S. Behavioral Health Plan, California dba OptumHealth Behavioral Health Solutions of California and its Pharmacy Benefit Manager (PBM), Express Scripts, Inc. (Express Scripts), on November 18 and 19, 2021.

The BHI identified three Knox-Keene Act violations in the areas of quality assurance and grievances and appeals:

1. The Plan does not ensure that only appropriately licensed health care professionals modify requests for services and fails to send providers and enrollees written notification letters required for modifications. Additionally, the Plan's behavioral health delegate is operating at variance with its utilization management policies and procedures filed with the Department.
2. Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.
3. Failure of customer service to identify all grievances.

Additionally, the Department identified two barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, and Cultural Competency, Health Equity and Language Assistance:

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

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

1. The Plan does not provide coverage for evidenced-based behavioral integration services.
2. The Plan has not developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location.

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

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

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

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

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[3] 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.[4]

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider

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

networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included 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.[5] To evaluate the Plan's operations for the review period of April 1, 2019, through March 31, 2021, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and its Behavioral Health 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 Department's Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan's BHI, the Department

[5] 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.

interviewed one provider and six enrollees whose input was considered for the Plan's BHI. The interviews were conducted between June and October 2021. The enrollees worked or lived in Sacramento, Alameda and Stanislaus Counties. The one provider who was interviewed serves the North Bay area, including Napa, Solano, Sonoma and Marin Counties.

The issues raised by interviewed enrollees included difficulties in finding providers who were a good fit, who have experience serving the LGBTQ community, including providing gender-affirming care, and who had experience treating particular diagnoses or providing particular treatments. Other enrollee concerns included difficulties getting out-of-network services authorized or covered when not available in network, and concurrent review taking place after expiration of previously authorized services resulting in gaps in treatment. The interviewed provider raised concerns about cumbersome and time-consuming claim submission processes for out-of-network providers.

PLAN BACKGROUND

The Plan operates as a commercial Health Maintenance Organization (HMO) with a total enrollment of 99,260 enrollees, all of which are commercial enrollees.[6]

The Plan delegates provision of mental health services to OptumHealth Behavioral Health Solutions of California and contracts with Express Scripts for pharmacy benefits.

The Plan received its Knox-Keene license on April 5, 2013 and provides health care services throughout fifteen counties in California: Alameda, Contra Costa, El Dorado, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, and Yolo.

[6] Enrollment data reported by the Plan as of March 31, 2021.

SECTION I: KNOX-KEENE ACT VIOLATIONS

QUALITY ASSURANCE

#1: The Plan does not ensure that only appropriately licensed health care professionals modify requests for services and fails to send providers and enrollees written notification letters required for modifications. Additionally, the Plan's behavioral health delegate is operating at variance with its utilization management policies and procedures filed with the Department.

Statutory/Regulatory Reference(s): Sections 1367.01(e), (h)(4); 1386(b)(1)

Supporting Documentation:

- OptumHealth Behavioral Health Solutions of California policy *Initial Authorization for Behavioral Health Services* (effective November 1989, most recently Quality Improvement Committee (QIC) approved June 2021)
- OptumHealth Behavioral Health Solutions of California policy *Peer-to-Peer Clinical Review* (effective November 1989, most recently QIC approved June 2021)
- 53 Utilization Management case files (April 1, 2019 through March 31, 2021)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.[7] Included in the types of documents required to be filed are plans' utilization management policies and procedures.[8]

OptumHealth Behavioral Health Solutions of California is a Knox-Keene licensed specialized health plan delegated by the Plan to provide behavioral health services to Plan enrollees. OptumHealth Behavioral Health Solutions of California is also delegated to conduct utilization review for requested services. As required by Section 1351, OptumHealth Behavioral Health Solutions of California filed its *Initial Authorization for Behavioral Health Services* policy with the Department in connection with its initial licensure.[9] The Plan filed the same policy with its application for licensure.[10] This policy describes, among other things, the OptumHealth Behavioral Health Solutions of California care advocate's role in connection with utilization review. When customer service staff receive requests for behavioral health services that require prior authorization, the calls are referred to a care advocate. Care advocates are licensed clinicians such as licensed marriage and family therapists or licensed clinical social workers. Care advocates gather clinical information, compare the clinical information with clinical criteria, and determine whether criteria are met for the requested service. If

[7] Sections 1386(b)(1), 1351, 1352.
[8] Sections 1351(m), 1367.01(b), 1367.01(j).
[9] See eFiling 20161669-24.
[10] See eFiling 20121442-5, Exhibit J-1-i.

the care advocate determines criteria are met, the care advocate may authorize the requested service.

With respect to limitations of the care advocate's role, the *Initial Authorization for Behavioral Health Services* policy states, in part:[11]

B. Care Advocacy Responsibilities

> 10. In the event a case fails to meet medical necessity criteria as outlined in the Level of Care Guidelines or Medicare behavioral health coverage guidelines for the level of care being requested, the case is referred to a USBHPC clinical peer for review. For information on referrals to a USBHPC clinical peer reviewer, refer to USBHPC policy and procedure 200.1.03, *Peer-to-Peer Clinical Review.*

The *Initial Authorization for Behavioral Health Services* policy requires care advocates to refer a request for service to a peer reviewer when clinical criteria are not met for the requested service. According to OptumHealth Behavioral Health Solutions of California's *Peer-to-Peer Clinical Review* policy, peer reviewers include board certified psychiatrists or addictionologists (for review of inpatient cases) and doctoral level clinical psychologists or psychiatrists (for review of outpatient cases).

Section 1367.01(e) states "No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity." The Department reviewed 53 utilization management files. Of the 53 files, four files (7%) demonstrated instances of requests for authorization for which care advocates did not determine the requested services were medically necessary but did not refer the cases to peer reviewers as required by the *Initial Authorization for Behavioral Health Services* policy. Rather, the care advocates modified the services by authorizing a different number of days or sessions than those requested by the provider, in violation of Section 1367.01(e) and at variance with the *Initial Authorization for Behavioral Health Services* policy.

Case Files:

File #17: The provider requested seven sessions of partial hospitalization. The care advocate, a licensed marriage and family therapist, authorized two sessions.

File #20: The provider requested seven days of mental health adolescent residential treatment. The care advocate, a licensed marriage and family therapist, authorized one day.

[11] *Initial Authorization for Behavioral Health Services* policy p. 7.

File #27: The provider requested 15 days of mental health residential treatment. The care advocate, a licensed clinical social worker, authorized six days.

File #51: The provider requested seven days of substance use disorder residential treatment. The care advocate, a marriage and family therapist, authorized six days.

File # 20 and File #51 also included the following language, indicating OptumHealth Behavioral Health Solutions of California was aware care advocates are not permitted to make modification decisions, yet attempted to get providers to evade Section 1367.01(e) requirements and avoid the limitations in its *Initial Authorization for Behavioral Health Services* policy:

> In an effort to expedite needed care, will you accept fewer number of days/units requested while reserving your rights to request additional days/units? Note: the alternative number of days/units is not to be considered denial that the requested number is not medically necessary, but rather a recommended change to your requested number of days/units based on the clinical information provided, our clinical guidelines and program requirements for concurrent review.
>
> Statement of Understanding:
> Yes, I understand this is not a denial but a change in my requested number of days/units based on the clinical information provided, your clinical guidelines and program requirements for concurrent review. I understand that I may request additional days/units at the next review.

Finally, Section 1367.01(h)(4) requires plans to send written responses to enrollees and providers regarding decisions based on medical necessity that result in denial, delay or modification of services. The response must include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons related to medical necessity. When OptumHealth Behavioral Health Solutions of California care advocates offer and authorize a level of care – whether the type of service, number of sessions, frequency of visits, etc. – that is different than the provider originally requested, and the provider did not voluntarily request the change, the utilization management decision is a modification. None of the four deficient files contained modification letters as required by Section 1367.01(h)(4). Failure to send modification letters denies enrollees the information and rights associated with Section 1367.01, such as the right to information about the reason for the decision and the criteria used as well as the right to appeal, independent medical review (IMR) rights and other important rights.

TABLE #1
Modification of Utilization Management Decisions

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Utilization Management Authorization Files	53	Only a licensed physician or licensed health care professional competent to evaluate the specific clinical issues may deny or modify requested services for reasons of medical necessity.	49 (93%)	4 (7%)
Standard Utilization Management Authorization Files	53	Responses of decisions that deny, delay or modify requested services shall include a clear and concise explanation of the reason for the decision, a description of the criteria or guideline used and clinical reasons regarding medical necessity.	49 (93%)	4 (7%)

Conclusion: Utilization management files demonstrate the Plan's behavioral health delegate utilized care advocates who rendered utilization management modification decisions contrary to the requirements of Section 1367.01(e). The files demonstrated providers did not voluntarily initiate a change in their request, but the change was initiated by OptumHealth Behavioral Health Solutions of California's care advocates.

When care advocates modified requested services, neither the Plan nor the delegate sent letters to the provider or enrollee as required by Section 1367.01(h)(4).

OptumHealth Behavioral Health Solutions of California's practice of using care advocates to make modification decisions is also at variance with the *Initial Authorization for Behavioral Health Services* policy, in violation of Section 1386(b)(1).

#2 <u>Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.</u>

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

Supporting Documentation:

- OptumHealth Behavioral Health Solutions of California policy *Reporting of Safety/Quality Issues* (QIC Approved December 2020)
- 21 potential quality issue files (April 1, 2019 – March 31, 2021)

Assessment: Health plans must have procedures for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.[12] Additionally, health plans' quality assurance programs must document that quality of care is being reviewed, problems are identified, and effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.[13]

The Plan delegates, among other things, behavioral health services and quality assurance functions related to behavioral health services to OptumHealth Behavioral Health Solutions of California.[14] Review of OptumHealth Behavioral Health Solutions of California files involving potential quality issues demonstrated that when a potential quality issue was raised by an enrollee who requested anonymity, OptumHealth Behavioral Health Solutions of California did not fully investigate the potential quality issue.

The Department reviewed all 21 potential quality issue files identified for the review period. Two of the 21 files involved enrollees requesting anonymity when submitting their complaints. In both cases, OptumHealth Behavioral Health Solutions of California limited its investigation based on the enrollees' request.

<u>Potential Quality Issue File #10</u>: A minor enrollee's parent complained about a psychiatrist, stating the provider was not responsive to the parent's requests and did not listen to the parent's concerns. The parent wanted to remain anonymous. Although the complaint and the electronic record were reviewed as part of OptumHealth Behavioral Health Solutions of California's investigation, the case file stated in part:

> [B]ecause the member wishes to remain anonymous it is not possible to contact the provider for a response to the complaint that the member is

[12] Section 1370.
[13] Rule 1300.70(a)(1).
[14] See Agreement for the Provision of Services Between U.S. Behavioral HealthPlan, California and Sutter Health Plan, effective January 1, 2013.

> not getting the level of care he needs and the provider is unresponsive to the member's requests . . . due to the concern that a request for the medical record will reveal the member's name, and that in contact with the provider he may guess the member based upon the allegations. Therefore, the case may be closed with no further action needed and a QoC rating of 0 – no QoC concern identified.

The case file went on to say there were two prior unsubstantiated quality complaints for the same provider. One of the prior complaints was subsequently retracted by the enrollee. The other prior complaint involved an enrollee who "wished to remain anonymous" and OptumHealth Behavioral Health Solutions of California's note stated "the determination of that prior complaint was that the complaint could not be investigated."

Potential Quality Issue File #16: An enrollee complained about care received from a licensed clinical social worker, stating the provider was inattentive and not helpful. The enrollee wanted to remain anonymous. The internal case file notes stated in part: "it is not advisable to contact the provider for a response to the issues in the complaint due to the complainant's request to remain anonymous and a concern that the provider may guess the member based upon the allegations." However, because review of information from the electronic record revealed three similar prior complaints about the provider, OptumHealth Behavioral Health Solutions of California elected to send "a general letter, not identifying the member" to the provider with a request for the provider to respond. Based on the provider's written response, OptumHealth Behavioral Health Solutions of California leveled the potential quality issue at 0 (zero) – no quality of care concern identified, and closed the case.

The cases described above demonstrate OptumHealth Behavioral Health Solutions of California's process is to limit its investigation of potential quality issues when an enrollee requests anonymity. By limiting the investigation, a health plan or its delegate is unable to consistently review all quality of care complaints or the performance of medical personnel. As a result of not conducting a full review, OptumHealth Behavioral Health Solutions of California cannot ensure all problems are identified, and that effective action is taken to improve care, or that follow-up is conducted when indicated. OptumHealth Behavioral Health Solutions of California closed investigation with minimal review when an enrollee requested anonymity unless a pattern of similar, prior complaints was identified.

The obligation health plans to comply with Knox-Keene Act requirements cannot be waived when the health plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.[15] Although the Plan delegates quality assurance for behavioral health services to OptumHealth Behavioral Health Solutions of California, the Plan is responsible to ensure compliance with Section 1370 and Rule 1300.70(a)(1). As part of the Plan's BHI,

[15] Section 1367(j).

the Plan submitted no documents demonstrating it monitored or audited OptumHealth Behavioral Health Solutions of California for its handling of potential quality issues or identified the practices described in this violation or implemented a corrective action plan.

Conclusion: The Plan does not ensure its delegate investigates all potential quality issues submitted by an enrollee when the enrollee wishes to remain anonymous. By not fully investigating potential quality issues, the delegate fails to continuously review the quality of care and the performance of medical personnel and is unable to document that quality of care is being reviewed, problems are identified or ensure effective action is taken in violation of Section 1370 and Rule 1300.70(a)(1).

GRIEVANCES AND APPEALS

#3: Failure of customer service to identify all grievances.

Statutory/Regulatory Reference(s): Rule 1300.68(a)(1)

Supporting Documentation:

- 44 customer service inquiry files (April 1, 2019 – March 31, 2021)

Assessment: Health plans must have procedures to ensure grievances are reviewed and resolved timely. A grievance is defined as "a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative."[16]

The Department reviewed 44 behavioral health inquiry files involving enrollee calls to the Plan. Of the 44 files, six[17] (14%) involved expressions of dissatisfaction.

Case File Examples:

Inquiry File #37: The enrollee telephoned the Plan after being charged for a telehealth visit stating she was told by a Plan representative the visits "would be free." The customer service representative advised the enrollee she was misinformed because behavioral health issues are handled by OptumHealth Behavioral Health Solutions of California, and therefore Plan representatives are unable to advise enrollees about mental health benefits. The customer service representative closed the matter seven minutes after receiving the call. Despite the enrollee's expression of dissatisfaction about a billing issue, the Plan did not identify the call as a grievance and there is no indication the Plan informed its delegate of the grievance.

Inquiry File #s 34, 35 and 36: These three files involved the same enrollee who telephoned the Plan on August 30, 2019, September 4, 2019 and September 12, 2019.

[16] Rule 1300.68(a)(1).
[17] Inquiry File #18, File #34, File #35, File #36, File #37 and File #44.

In each of the three calls, the enrollee stated he was having difficulty finding a provider. In the first call, he stated OptumHealth Behavioral Health Solutions of California provided him with lists of providers, but he was having difficulty and indicated he was having to make several calls. The customer service representative informed the enrollee a grievance could be submitted to OptumHealth Behavioral Health Solutions of California.

In the second call, the enrollee stated he was “still having issues” finding a provider, explaining that when he called providers, “they state they don’t treat that issue.” The customer service representative noted the Plan’s system showed the enrollee had spoken to other Plan representatives about the same issue. While the customer service representative had the enrollee on hold, the enrollee hung up.

In the third call, the enrollee complained to the Plan he was having problems finding a provider, had called multiple places and had been trying for two months to find a provider. The Plan’s customer service representative explained to the enrollee that mental health benefits are through OptumHealth Behavioral Health Solutions of California and offered to get someone from OptumHealth Behavioral Health Solutions of California on the telephone line. The enrollee responded he “didn’t want to mess with that” and further stated “there are therapists out there, but no one responds.” The enrollee agreed to be transferred to the delegate’s urgent telephone line.

Each of the enrollee’s three telephone calls to the Plan were handled by different customer service representatives and in each case, the customer service representative closed the matter without identifying the enrollee’s complaints or expressions of dissatisfaction as grievances. Although the Plan delegates the handling of grievances and appeals to OptumHealth Behavioral Health Solutions of California, the Plan must have a process in place to ensure that enrollee grievances received by the Plan are accurately identified and forwarded to the delegate. Review of Plan inquiry files demonstrated the Plan failed to consistently identify all grievances.

Conclusion: The Plan’s customer service representatives did not consistently identify all grievances when handling enrollee telephone calls. Failure to identify grievances may result in the Plan or its delegate not tracking all grievance trends. Because the Plan failed to identify all grievances received by its customer service representatives, the Department found the Plan in violation of Rule 1300.68(a)(1).

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

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

#1: <u>The Plan does not have a process to support integrated behavioral health services.</u>

Summary: The Plan does not have a policy or procedure that addresses integrated behavioral health services. Behavioral health integration is an approach to delivering mental health care that involves primary care and behavioral health providers working together using a team-based approach. Additionally, when asked to provide procedure codes for services covered by the Plan, the Plan provided no procedure codes related to integrated behavioral health services.

#2: <u>The Plan has not developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing BH services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location.</u>

Summary: The Plan and its delegate, OptumHealth Behavioral Health Solutions of California, were asked to produce documents describing how they identify disparities across the enrollee population for age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location. The Department also requested documents evidencing the Plan's cultural competence related to the delivery of behavioral health services. The Plan provided no response. OptumHealth Behavioral Health Solutions of California provided two reports containing data that reflected California population demographics cited from the 2010 U.S. Census. This outdated information was then compared with OptumHealth Behavioral Health Solutions of California's statewide network, rather than including an analysis involving only the Plan's network. Other OptumHealth Behavioral Health Solutions of California's documents submitted in response to requests for policies, procedures and processes that address cultural competence in the delivery of health care services included documents limited to addressing race/ethnicity and language but did not address other characteristics, such as national origin, gender, sexual orientation, age, and physical or mental abilities. OptumHealth Behavioral Health Solutions of California also provided

policies that addressed assistance provided for those with limited English proficiency or hearing or vision impairment, but no cultural competence-related processes.

Neither the Plan nor OptumHealth Behavioral Health Solutions of California provided policies and procedures pertaining to community outreach and engagement with identified racial, cultural, linguistic, and smaller populated cultural communities including but not limited to the tribal/Native American population. Finally, with respect to training provided to staff, delegates and contracted entities pertaining to cultural awareness, coordination of services and delivery of behavioral health services to a diverse population, the Plan stated it requires annual training pertaining to the Language Assistance Program. OptumHealth Behavioral Health Solutions of California's response indicated it only provides training to its licensed clinical staff upon hire, but there was no indication of training provided to other staff or training at regular intervals.

Regarding cultural competence training for providers, the Plan provided a training guide that describes the Plan's language assistance program. OptumHealth Behavioral Health Solutions of California provided a PowerPoint training document made available to its California providers that states cultural and health disparities exist but provided little instruction on addressing the disparities.

The Department also requested documents describing oversight and monitoring of contracted providers to ensure providers meet the cultural, racial, ethnic, and linguistic needs of enrollees. In response, OptumHealth Behavioral Health Solutions of California provided data pertaining to its statewide business as compared to U.S. Census data for California. Plan documents addressed only the language assistance program.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified three Knox-Keene Act violations and two barriers to care not based on Knox-Keene Act requirements. Furthermore, the Department identified no notable Plan initiatives or operations.

The Plan was afforded an opportunity to respond to any factual errors in this Report and submit a CAP reasonably calculated to correct the identified Knox-Keene Act violations.

The Plan may submit a statement describing actions the Plan has or will take to address the four 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 **Friday, September 8, 2023,** using the DMHC Web Portal process described below.

The Plan must submit its Response, if any 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: INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Laura Beile	Supervising Health Care Service Plan Analyst
Marie Broadnax	Staff Services Manager II
Lezlie Micheletti	Health Program Specialist II
Christian Jacobs	Health Program Specialist II
CONSULTANT TEAM MEMBERS: THE INS COMPANIES, INC.	
Heather Harley	Project Manager
JoAnn Baldo	Investigator
Anita Edington	Investigator
Sam Muszynski	Investigator
Marilyn Vadon	Investigator
Katie Dublinski	Investigator
Donna Lee Williams	Investigator

APPENDIX B: PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: SUTTER HEALTH CARE PLAN	
Trisha Burgos	Compliance Officer
KaYee Chow	Manager, Operations
Stacie Clarke	Senior Customer Service Agent
Lola Ellis	Regulatory Compliance Analyst
Jill Glenn, RN	Director of UM/CM and Delegation Oversight
Ramon Gonzalez	Director, SHP Member Services
Christine Keating-Hawlisch	Director, SHP Customer Engagement
Tanya Khandzhiyev	Manager, Quality Program
Noelle Lee, PharmD	SHP Pharmacy Manager
Zsole Munoz	Director, Operations
Connie Powell	Manager, SHP Member Services
Stacey Shelly	Counsel
Kevin Sims	Customer Service Agent
Susan Stephenson, RN	Director of Quality and Accreditation
Melissa Vargas	Manager, Operations

DELEGATE STAFF INTERVIEWED FROM: USBHPC	
Alicia Muellner	BH Credentialing Specialist
Angela Lang	Senior Grievance Reviewer
Dr. Joan Odom	BH Medical Director
Dr. Randall Solomon	USBHPC Chief Executive Officer /Regional Medical Director
Eileen Sweeters	Complaints Manager
Fran Bridge	Director BH Regulatory Audits and Reporting
Jack Hallmark	Director, BH Business Process
Jennifer Varraux	Director, BH Claims and Appeals
Jose Garcia	Manager of BH Customer Service
Cindy McMasters	QI Specialist
Kimberly Montiel	Supervisor of BH Customer Service
Lacey Kostiuk	BH Claims Auditor Consultant
Lisa Rose	Director, BH Clinical Operations
Lyndi Gowette	Manager, BH Regulatory/Client Audit
Michelle Breazell	BH Senior Business Process Consultant
Michelle Hart	Manager, BH Provider Data/Directory Accuracy
Rachael Kitchen	Associate Director, EM
Richard Rodriguez	Director of BH Provider Services
Scott Ward	BH Clinical Program Manager

DELEGATE STAFF INTERVIEWED FROM: USBHPC	
Dr. Sean Weber	Director, Quality Improvement, USBHCP/ OptumHealth Behavioral Health Solutions of California
Susan Wagers	Complaints Team Lead
Tonya Shean	Compliance Lead
Crimsen Novack	Customer Service Staff

DELEGATE STAFF INTERVIEWED FROM: Express Scripts, Inc.	
Austin Andrews	Quality review and Audit Advisor, Client Audit
Preston Black	Pharmacy Prior Authorization Senior Manager, Coverage Review
Wendy Boyles	Pharmacy Clinical Consulting Senior Manager, Clinical Director
Josh Herbert	Pharmacy Prior Authorization Advisor, Coverage Review.
Rebecca Roell	Pharmacy Prior Authorization Manager, Coverage Review
Brian Schumm	Clinical Pharmacy Senior Manager, Coverage Review Department
Joel Troutt	Senior Advisor, Account Management

APPENDIX C: LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries	44	08043739 08036255 08014570 07665500 07606246 08473860 08468528 08434953 08352341 08062176 08062128 08061177 08061088 08482472 08432278 08323073 06780408 07011017 06927239 06921657 06920582 08097321 08097295 08047578 07582976 07580436 07570294 08106041 08100105 07258641 08345521 08116522 06608184 07133228 07105430 07094140 08151034 08149251 08108806 08448919

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries (continued)		08448590 06875005 07855975 07854562
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Provider Complaints	4	202002078708 202006023406 20201111833 202102247926
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Denied Claims	30	007383929300 007259881800 007313569603 007157961300 008533083600 007272653600 007194622400 007376809400 007333893900 007306604100 20191203013271 007243763102 007280092600 007349140000 007202134500 007186361600 007398281500 007325768500 007370468100 007282069700 007210571100 007301905200 007254832000 007284127700 007381625900 007167849900 007361086500 007221563200 008532208700 007408281800

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims	32	007404177900 007380000800 007245608400 007347158600 007256523500 007382934400 007162708000 007352778400 007370866000 007178445801 007218878500 007441459400 007236613500 007223260200 007308121400 007353364300 007178016700 007376311400 007429775900 007285431800 007163001000 007242793400 007413957500 007440001400 007423777100 007313971900 007321945600 007289133200 007259607900 007262510600 007305479500 007235340000

Type of Case Files Reviewed	# of Files	Case ID Number
Grievance and Appeals	44	8017110 WNQWL4B5 1424735 WNQWL4B5 844B86RD 7461587 93X2ZF43 9YB463D8 7569738 6935724 V1BTV591 7613580 6965313 7195514 7324184 7014179 97510112 7504252 97309975 94077240 7684678 RB16GC63 7728690 933068677 59427 201903168606 7720340 38KPMCGC 7809857 6885224 97619984 93089992 7725270 6933281 7358682 91521105 7762414 8445056 6758460 97791687 98813530 7409755 98458636 92595376

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management - Authorizations	53	QV36MJ-01 V27TQS-06 4J94ZG-01 BS5N6I-0 ADTGWM-01 SZTFFB-03 7TXC6H-01 MYY4HH-01 DR6JLB-01 DYZCKJ-01 S7C86K-02 4WDR8I-01 UB5TNW-02 FN1CTT-01 BS82DR-01 PQ6HMB-01 RHBQRL-02 XGDWJW-02 S6G8TX-01 9KS3GR-04 6KBFTY-01 ZK8R1T-05 X4DLWD-01 WRSDQN-02 3W3H9J-01 J3V6PM-02 XKVFCY-01 XGS14L-02 XCZT4H-01 5BPJPQ-01 LFXSWT-02 EQJBTE-01 BQG5WS-02 9GW3SX-01 XF4CZZ-01 NZNPJM-01 WQHB1B-02 W466MM-01 T6X4GL-04 97Y9YB-01 RY51MC-04 L24NHK-01 VV9VHE-02 WCFVBA-01 DB9CDY-01

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management – Authorizations (continued)		7WW41C-01 G8VNSG-02 IXFX6L-05 573LRX-01 1JYX5K-01 PH38KD-02 69CVJZ-02 TM7X2X-01
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Utilization Management - Denials	30	RZYH71V4 8HSDK5Z3 44ZF6VLN 1X3F1RZX QX24TVQ4 MCNX6291 HX1P8Y35 BX6LJCQE IN8HZ5SZ ZP9QBSHC S785C1DC 5ZWXK2LG ZB1DNNFT 844B86RD 13DS765K 19D2V6RW U398M8FI 5MBKVJZX BN2LL7KI G8RL8H8X IN8HZ5SZ W2T5C7NL 93X2ZF43 W3ZRCD55 ET1NFWLY 3JCHS39H BGWXBLJ1 932436140 DV2CL2NX H3MP5M2U

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Requests for Out of Network Behavioral Health Provider	31	YQ55KE-01 ESWN1B-01 1P5V5S-01 RVJF1V-01 ULQ69V-01 WQ1KFT-01 SHHRQC-03 P4N9XP-01 2KSMJZ-01 327TWF-01 IR7TYN-01 DV3CQD-03 ZG5TPT-01 X2CPSH-01 F2C6LA-01 JPRGWR-01 PTWPGL-01 XNN92P-01 E8PLJQ-01 R9G7BL-02 5653CS-01 H65Q1B-01 MVGK8J-01 FP35DA-01 SPZ8PD-01 1RDKVH-01 MX639W-10 FJXSTH-01 7QZ1NT-01 URHX3X-01 V7XCGT-01

Type of Case Files Reviewed	# of Files	Case ID Number
Potential Quality Issues	21	0000021300 0000021734 0000021227 0000021017 190504 190706 191001 191003 191206 200104 200203 200305 200403 200705 200709 200905 201001 201003 201003 210103 210304

SUTTER HEALTH PLUS CORRECTIVE ACTION PLAN RESPONSE

QUALITY ASSURANCE	
Deficiency Statement	**Deficiency #1**: The Plan does not ensure that only appropriately licensed health care professionals modify requests for services and fails to send providers and enrollees written notification letters required for modifications. Additionally, the Plan's behavioral health delegate is operating at variance with its utilization management policies and procedures filed with the Department. Cal Health & Saf Code § 1367.01(e) and (h) and 1386(b)(1)
Action(s) Taken	The Plan reviewed Deficiency #1 with U.S. Behavioral Health Plan, California (USBHPC). SHP contracts with USBHPC, a licensed health plan, to provide mental health and substance use disorder services to SHP members. USBHPC provided the following information in response to the deficiency. **USBHPC Response:** The Plan reviewed Deficiency #1 with USBHPC and USBHPC provided the following information in response to the deficiency: While USBHPC acknowledges the language documented within certain case records may have inadvertently described USBHPC's medical necessity review determination as a modification, USBHPC respectfully asserts such determinations were authorization determinations, not modification determinations. Behavioral health lengths of stay are determined based upon the *specific needs of the member* in accordance with Cal Health & Saf Code § 1374.72(a)(3)(A). As such, when conducting medical necessity reviews of a proposed course of MH/SUD inpatient care, or facility-based outpatient care, specialized behavioral health plans assess whether a member meets the medical necessity criteria for the treatment type requested. If a member meets criteria for the treatment type requested, USBHPC generally authorizes a certain number of units upfront with the understanding additional units (e.g., days or sessions) may be requested by the provider during subsequent concurrent reviews in which the provider submits updated clinical information so that USBHPC may assess whether ongoing care is medically necessary. It is uncommon for a behavioral health provider to request benefit authorization for a long duration of behavioral health treatment upfront (e.g., 28 days of residential treatment), but it does happen on

	occasion. In such scenarios, when the member meets criteria for the treatment type requested, USBHPC and the provider typically come to an agreement on the number of units to be authorized upfront with the understanding additional units may be requested during subsequent concurrent reviews. When this agreement occurs between the provider and USBHPC, the provider's original requested number of units is considered rescinded, and the determination is categorized as an authorization determination. In many cases, USBHPC ultimately ends up authorizing as many, if not more, units during the collective prospective and concurrent review process than the number of units originally requested by the provider during the initial prospective review. In the event a provider does not agree to the terms (i.e., number of units to be authorized upfront followed by subsequent concurrent reviews in which the provider may request additional units), USBHPC would categorize the determination as a partial denial and the case would be referred to peer-to-peer review with an appropriately licensed health care professional in accordance with Cal Health & Saf Code § 1367.01(e) and (h). However, this rarely occurs as both the provider and USBHPC recognize it would be confusing to the member if USBHPC issued a partial denial letter for certain dates of service because the provider and USBHPC failed to come to an agreement on the initial number of units to be authorized upfront during the prospective review process and USBHPC subsequently authorized additional units for the same dates of service during the concurrent review process (i.e., in this scenario, there would be nothing for the member to appeal). Notwithstanding the above, USBHPC will implement the following measures to ensure compliance with Cal Health & Saf Code § 1367.01(e) and (h) and 1386(b)(1): • USBHPC is transitioning to a new note type which removes the case note language cited in the report. • Ensure better documentation of the provider's and USBHPC's agreement on the number of units to be authorized upfront, and the provider's understanding that additional units may be requested during the concurrent review process, within the individual member case notes. • Staff reeducation on the process.

	• Complete focused monitoring for three (3) month post training to ensure compliance with all applicable policies and procedures.
Supporting Documentation	• Def 1_CA Guidance Education_Agenda_Participants
Implementation Date* (Anticipated or Completed)	Transition to new note system – Completed on July 31, 2023 Staff re-education – Completed on August 4, 2023 Process monitoring – Anticipated completion by November 4, 2023
Deficiency Statement	**Deficiency #2**: **Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.** Rule 1300.70(a)

Action(s) Taken	**SHP Response:** Throughout the remainder of 2023, SHP will review USBHPC's PQI files as part of the annual audit. If deficiencies are identified during the oversight activity, corrective actions will be implemented as needed. During these audits, SHP will confirm that USBHPC has processed anonymous requests in accordance with their process. The Plan reviewed Deficiency #2 with USBHPC. SHP contracts with USBHPC, a licensed health plan, to provide mental health and substance use disorder services to SHP members. USBHPC provided the following information in response to the deficiency. **USBHPC Response:** • USBHPC has updated the PQI Complaint investigation process where the member requests to remain anonymous. The process will now include all investigation actions, including outreach to the provider without disclosing the member identification, if applicable to ensure all complaint allegations are appropriately addressed
	• Developed process document • Completed California Quality staff training
Supporting Documentation	• Def 2_ Anonymous CA KK Complaints Investigation Workflow • Def 2_PQI Staff Training_Meeting_Redacted
Implementation Date* (Anticipated or Completed)	USBHPC: Completed on June 12, 2023 SHP: Will be completed by December 31, 2023, and annually, thereafter.
GRIEVANCES AND APPEALS	
Deficiency Statement	**Deficiency #3: Failure of customer service to identify all grievances.** Rule 1300.68(a)(1)

Action(s) Taken	**SHP Response:** SHP's Customer Service training document, 3A_MS_Knowledge Management Material Updates, was revised to ensure expressions of dissatisfaction related to behavioral health services or benefits are warm transferred to the USBHPC customer service line for appropriate handling. A call script for behavioral health related phone calls was developed to ensure all relevant information is gathered and documented in the interaction log. SHP completed refresher training for all customer service agents on July 26th. This training consisted of reviewing call handling protocols when a complaint is identified, documentation expectations and scenario reviews. Customer Service Management began performing weekly audits on August 1st to ensure established protocols are being followed and will continue for the first 8 weeks following training. Monthly audits will be done for the next 12 months to ensure appropriate handling of calls and adherence to training.
Supporting Documentation	• 3A_MS_ Knowledge Management Material Updates • Member Services Training Agenda
Implementation Date* (Anticipated or Completed)	• Knowledge Management Update completed on June 20, 2023 • Audit Form, Call Script, and Workflow updates were completed on August 1, 2023 • Staff Training was completed on July 26, 2023