DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

COUNTY OF VENTURA
DBA VENTURA COUNTY HEALTH CARE PLAN

AUGUST 31, 2023

Behavioral Health Investigation
Ventura County Health Care Plan
August 31, 2023

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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 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 (health plans) to further evaluate health plan compliance with California laws and to assess whether enrollees have consistent access to medically necessary behavioral health services, and to evaluate challenges providers experience in delivering medically necessary behavioral health services. The full-service commercial health plans will be investigated in phases. The investigation of Ventura County Health Care Plan (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 (MH/SUD) services or collectively, behavioral health services.[2] The investigation team interviewed the Plan, its behavioral health delegate, U.S. Behavioral Health Plan, California (USBHP) dba OptumHealth Behavioral Solutions of California and its Pharmacy Benefit Manager (PBM), Express Scripts, Inc. (Express Scripts), on November 15 and 16, 2021.

The BHI identified three Knox-Keene Act violations in the areas of Appointment Availability and Timely Access and Quality Assurance:

1. The Plan and the Plan's delegate do not monitor provider referrals and specialist care as required by Rule 1300.67.1(e).
2. 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.
3. Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.

[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.

Additionally, the Department identified the following 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:

1. The Plan does not have a process for providing integrated behavioral health 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 and 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,

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

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 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 that are 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 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

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

interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan's BHI, the Department interviewed a provider whose input was considered for the Plan's BHI. The interview was conducted in July 2021. The provider serves Ventura County and raised a concern involving enrollee difficulties in obtaining ongoing appointments. Despite the Department's attempt to engage Plan enrollees, the Department received no response from Plan enrollees willing to be interviewed.

PLAN BACKGROUND

The Plan is a full service, not-for-profit health plan operated by the County of Ventura, with a total enrollment of 11,890 enrollees, of which 11,405 are commercial enrollees.[6] The Plan is headquartered in Oxnard, California and received its Knox-Keene license on June 6, 1996. The Ventura County Board of Supervisors serves as the Plan's governing board. The Plan offers small and large group commercial HMO[7] products to employees of the County of Ventura and their dependents and to providers who provide services within, or in conjunction with, the county health care system and their dependents. The scope of review for this survey encompasses all of the Plan's lines of business. The Plan delegates provision of mental health services to OptumHealth Behavioral Health Solutions of California and utilizes a PBM, Express Scripts, for pharmacy benefits.

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

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan and the Plan's delegate do not monitor provider referrals and specialist care as required by Rule 1300.67.1(e)

Statutory/Regulatory Reference(s): Rule 1300.67.1(e)

Assessment: Rule 1300.67.1(e) states that within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including "an adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and the associated health professionals."

The Department requested copies of Plan or delegate reports pertaining to the monitoring of provider referrals and specialist care. The Plan provided no response. OptumHealth Behavioral Health Solutions of California responded that it "does not monitor this information."

Conclusion: The Plan is in violation of Rule 1300.67.1(e) for failing to ensure that the Plan or its delegate have a system to document and monitor referrals to behavioral health providers and monitor the follow up of health care documentation.

QUALITY ASSURANCE

#2: 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 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)
- 67 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.[8] Included in the types of documents required to be filed are plans' utilization management policies and procedures.[9]

OptumHealth Behavioral Health Solutions of California is a Knox-Keene licensed specialized health plan that is 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.[10] This policy describes, among other things, the 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 the care advocate determines criteria are met, the care advocate may authorize the requested service.

With respect to the 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

[8] Sections 1386(b)(1), 1351, 1352.
[9] Sections 1351(m), 1367.01(b), 1367.01(j).
[10] See eFiling 20161669-24.
[11] *Initial Authorization for Behavioral Health Services* policy p. 7.

requests for authorization of health care services for an enrollee for reasons of medical necessity."

The Department reviewed 67 utilization management files. Of the 67 files, eight files[12] (14%) 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 Examples:

File #3: Six days of partial hospitalization were requested. The care advocate, a licensed marriage and family therapist, modified the request by authorizing five days.

File #8: Three days of inpatient services were requested. The care advocate, a licensed marriage and family therapist, modified the request by authorizing two days.

File #38: Five days of inpatient services were requested. The care advocate, a licensed clinical social worker, modified the request by authorizing two days.

Six[13] of the eight deficient files 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.

[12] Utilization Management File # 3, File #4, File #8, File #33, File #38, File #56, File #60, File #65.
[13] Utilization Management File # 3, File #8, File #38, File #56, File #60, File #65.

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 eight 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	67	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.	59 (86%)	8 (14%)
Standard Utilization Management Authorization Files	67	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.	59 (86%)	8 (14%)

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).

#3: Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.

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)
- Six 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.[14] 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.[15]

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.[16] 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 six potential quality issue files identified for the review period. One of the six files involved an enrollee who requested anonymity when submitting their complaint. OptumHealth Behavioral Health Solutions of California limited its investigation based on the enrollee's request.

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

Potential Quality Issue File #5: A minor enrollee's parent complained about conditions and supervision of a mental health inpatient facility during her child's stay. The parent wanted to remain anonymous. Although the complaint, the electronic record and the enrollee's clinical records were reviewed as part of OptumHealth Behavioral Health Solutions of California's investigation, the case file stated in part:

> The complainant requested to remain anonymous, so the facility could not be asked specific questions related to these 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 also listed, as part of the investigation, eight prior complaints about the facility since 2017, including four quality complaints in 2020. One of the prior 2020 quality of care complaints was substantiated. Notwithstanding the number of prior complaints, OptumHealth Behavioral Health Solutions of California conducted a minimal investigation and closed the case.

OptumHealth Behavioral Health Solutions of California's process involves limiting 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.

The obligation of 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.[17] 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, 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).

[17] Section 1367(j).

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

The following is an overview 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 care. 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: The Plan does not have a process for providing integrated behavioral health services.

Summary: 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. 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: 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.

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 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.

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 provided no response. 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.

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.

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 two 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: VENTURA COUNTY HEALTH CARE PLAN	
Dee Pupa	Plan Administrator
Howard Taekman M.D.	Medical Director
Mitch Craven	Regulatory Compliance
Faustine Dela Cruz	Director of Health Services
Meriza Ducay	Quality Assurance Nurse
Christina Woods	Director of Member Services
Erick Hernandez	Customer Service Manager
Noemi Solomon	Provider Services Program Administrator
Michelle Myricks	Claims Manager
Norma Esparza	Credentialling Program Administrator

DELEGATE STAFF INTERVIEWED FROM: OPTUMHEALTH BEHAVIORAL HEALTH SOLUTIONS OF CALIFORNIA	
Alea Owens	BH Audit Specialist
Alicia Muellner	BH Credentialing Specialist
Angela Lang	Senior Grievance Reviewer
Dr. Joan Odom	BH Medical Director
Dr. Randall Solomon	OptumHealth Behavioral Health Solutions of California 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
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
Sean Webber	Director, Quality Improvement, USBHCP/ Optum BH
Kimberly George	QI Specialist
Marci Zaree	QI Specialist
Susan Wagers	Complaints Team Lead

DELEGATE STAFF INTERVIEWED FROM: OPTUMHEALTH BEHAVIORAL HEALTH SOLUTIONS OF CALIFORNIA (continued)	
Tonya Shean	Compliance Lead
Heather Wilson	Associate General Counsel
Cheryl Fiemann	Director, Client Management
Roxanne Casper	Senior Client Sales Manager
Meriza Ducay	Quality Assurance Nurse
Christina Woods	Director of Member Services
Dr. Ruth Kenzelmann	Vice President, Employee Assistance Program Call Centers
Crimsen Novack	Customer Service Staff

DELEGATE STAFF INTERVIEWED FROM: Express Scripts, Inc.	
Julie Lai	Pharmacy Director

APPENDIX C: LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries	15	CLTP0000205510 CLTP0000205721 CLTP0000205628 CLTP0000206044 CLTP0000206799 CLTP0000206351 CLTP0000206615 CLTP0000206586 CLTP0000207502 CLTP0000207062 CLTP0000207014 CLTP0000207124 CLTP0000207267 CLTP0000207373 CLTP0000207328
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Requests for Out of Network BH Provider	7	20201243406 20202184641 20202264531 20203276294 20203305849 20209242089 20201166608
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Provider Complaints	1	202101062239
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issues	6	19-05-5 20-02-04 20-07-07 20-08-07 20-10-02 20-12-05

Type of Case Files Reviewed	# of Files	Case ID Number
Experimental/Investigational or Benefit Denials	13	AMNZHJ46 FNM37KFI NV4NDVP3 5PM9S131 81WHNYYB BKQM49M8 WBLFT9FS ZBHYZDJN F3P9LJ22 676C9XB9 PTTGBJ18 PZK7K4ZL 7SX4KTHM
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issues	6	19-05-5 20-02-04 20-07-07 20-08-07 20-10-02 20-12-05
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievance and Appeals	9	92533779 92667220 94971159 97762735 97654865 100612029 100612046 101191835 100352872

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims	30	20X691312600 21X161546500 20X482534400 19X293109100 19X171689000 19X192772300 20X226290900 19X353513900 19X423064500 20X288583700 19X147647100 20X144285200 21X194924000 20X068411700 20X156237500 19X175391700 20X374180700 19X326519700 21X126861700 20X498174900 20X264342100 20X097569300 20X112383800 20X395453200 20X060675800 19X253262500 20X017084900 19X300406000 19X456985900 20X286227200

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims	30	20X315380800 19X438175700 20X160019400 20X113463600 19X506721300 21X085284402 20X164552700 20X012381401 19X229055800 19X523537000 20X690661500 19X188919201 21X086294300 20X387804600 20X221824900 20X070875100 20X145240500 19X551161000 19X313146300 21X086282500 21X053832000 19X495394801 20X458997700 21X019328301 19X532175300 19X178075901 19X399575600 20X494965500 20X547061301 19X407599400

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management	67	VLPF6D-01 DD6MZF-06 17VHWI-02 M3CYMX-01 7KKWCX-02 22Y3XD-02 S7DK2V-01 HDLKHP-02 QLGN9U-01 L21S3Z-01 X7V4KY-01 JG2HDA-01 S5XVYT-01 N4Y9GA-03 P396DZ-03 Q3X5CQ-01 GLJ6SF-01 RRNSPG-02 91959271 Q9XFRD-01 L6NYQR-01 T2BP6I-01 E4VHCF-01 NFXX4P-02 3XKMCW-01 ZTPSZA-01 PC8LDI-01 L6N33Z-03 97430815 B9BLCF-01 N3F8YZ-02 7KKWCX-01 ZX23DC-01 LWDXPS-03 NJK4FV-01 2FN4WS-01 MRML6M-01 211PSF-04 T9JZRM-02 D3X33U-01 UBHZJJ-01 LTMSKC-01 D614CG-01 DQNS2W-01 E9PPBI-02

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management (continued)		HGDTRD-01 T7JV5Z-01 UYRLZZ-01 JKY7PE-01 LSP35Z-03 EH1PBB-01 7GJMXV-01 PHPRDJ-01 HXQ9YG-02 EVZ29P-01 L8X6ND-02 CMCVMT-05 94293905 101075389 211PSF-05 KMYQWI-01 UHBL2T-03 TW21GU-01 TJNN7L-01 HKD51K-03 TJJW5Y-02 VCBGGY-01

VENTURA COUNTY HEALTH CARE PLAN
CORRECTIVE ACTION PLAN RESPONSE

VIOLATION #1

CORRECTIVE ACTION PLAN

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan and the Plan's delegate do not monitor provider referrals and specialist care as required by Rule 1300.67.1(e)

Statutory/Regulatory Reference(s): Rule 1300.67.1(e)

USBHPC/Plan's Response: The Plan's delegate, USBHPC/OptumHealth, filed a factual errors response to Violation #1 on June 7, 2023.

The statement filed was as follows:

> USBHPC respectfully disagrees with Violation #1. The Rule 1300.67.1(e) requires an adequate system of documentation of primary care physician (PCP) referrals to specialty physicians or health professionals, e.g., cardiology, neurology, psychiatry, etc. As a specialized behavioral health plan, USBHPC would not be in possession of documentation of PCP referrals to specialty providers.

USBHPC/Plan's Updated Corrective Action Plan 09/08/2023:

> Addition, referrals are not required to obtain Behavioral Health services, the member can self-refer. Requiring referrals would impose an additional barrier and burden to the member.

No further responsive Corrective Action Plan is provided by USBHPC/OptumHealth as to Violation #1.

VIOLATION #2

CORRECTIVE ACTION PLAN

SECTION I: KNOX-KEENE ACT VIOLATION

QUALITY ASSURANCE

USBHPC/Plan's Updated Corrective Action Plan 09/08/2023:

The Plan's delegate, USBHPC/Optum Health, provides this updated Corrective Action Plan responsive to the Knox-Keene Violation #2 as follows:

Violation Statement: Violation #2: 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.

Action(S) Taken:

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.

There is no "one size fits all" length of stay for behavioral health treatments. 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, it is industry standard for specialized behavioral health plans to assesses whether a member meets the medical necessity criteria for the treatment type requested. If a member meets criteria for the treatment type requested, the Plan 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 the Plan may assess whether ongoing care is medically necessary.

It is unusual 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, the Plan 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 the Plan, the provider's original requested number of units is

considered rescinded, and the determination is categorized as an authorization determination. In many cases, the Plan ultimately ends of 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 rare 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), the Plan 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 the Plan recognize it would be confusing to the member if the Plan issued a partial denial letter for certain dates of service because the provider and the Plan failed to come to an agreement on the initial number of units to be authorized upfront during the prospective review process and the Plan 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 Plan'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 and the updated policies
- Complete focused monitoring for three (3) month post training to ensure compliance with all applicable policies and procedures.

Supporting Documentation: None

Implementation Date*: (Anticipated or Completed)
Transition to new note system – Anticipated completion July 31, 2023
Staff re-education – Anticipated no later than August 4, 2023
Process monitoring – Anticipated August 4, 2023 – November 4, 2023

USBHPC Response
09/07/23:
- The standard following documentation has been decommissioned and no longer will be in use effective July 31, 2023:

> *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 under 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.

- USBHPC completed applicable staff training by August 4, 2023, on how to educate providers during clinical review regarding the determination for Level of Care (LOC), service intensity, set number of days/units, including how to accurately document such discussions with providers within clinical case notes. Please see document: Violation 2_CA Guidance Education_Agenda_Participants
- Monitoring to ensure use of appropriate template letter(s) has begun and will conclude November 4, 2023 (90 days)

VIOLATION #3

CORRECTIVE ACTION PLAN

SECTION I: KNOX-KEENE ACT VIOLATIONS

#3: Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified.

Statutory/Regulatory Reference(s): Sections 1730 and Rule 1300.70(a)

USBHPC/Plan's Response and USBHPC/Plan's Updated Corrective Action Plan 09/08/2023: The Plan's delegate, USBHPC/OptumHealth, filed a factual errors response to Violation #3 on June 7, 2023.

The statement filed was as follows:

> USBHPC respectfully disagrees with Violation #3 that "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)." USBHPC has neither violated Section 1370 nor Rule 1300.70(a)(1) for the following reasons:
>
> **I. USBHPC permits enrollees to submit anonymous grievances to encourage open communications on quality of care concerns so that the Plan may investigate and take action when necessary to ensure care is being delivered in accordance with professionally recognized standards of practice to all its enrollees.**
>
> USBHPC has consistently adhered to the rules and regulations required within Sections 1368 and 1370, as well as Rule 1300.70 of the Knox-Keene Act. To ensure quality assurance throughout its grievance system process, USBHPC permits enrollees to submit anonymous grievances relating to quality of care concerns. Permitting enrollees to submit anonymous grievances encourages an open dialogue where enrollees feel comfortable expressing their concerns, which allows the Plan to investigate and take action to improve quality of care when necessary for all its membership. Policy 400.0.03 - *Resolution of Enrollee Grievances*, pg. 6, par. 6 (last submitted to the Department on 02/12/2021, Filing # 20204519) sets forth in pertinent part:
>
> > "For complaints in which the enrollee requests to remain anonymous, the USBHPC staff member receiving the

complaint should explain that USBHPC will make every effort to investigate the complaint but will be limited in scope. For example, USBHPC may not be able to fully investigate the allegations within the complaint without using the enrollee's name. USBHPC may be limited in our ability or may not be able to require the practitioner/facility to take corrective action in addressing the specific enrollee's issues."

This open dialogue allows USBHPC to investigate and monitor quality of care trends and patterns so that the Plan may work with its network providers on implementing measures to improve quality of care as needed.

II. USBHPC investigates anonymous grievances to the fullest extent possible.

Quality of care complaints submitted anonymously are investigated to the fullest extent possible while making every effort to retain the confidentiality of the enrollee's identity. When reviewing a grievance where the enrollee requests to remain anonymous, a Quality Improvement (QI) Specialist reviews each member grievance with the Optum Medical Director. When developing a plan for investigation, USBHPC takes into consideration both the content of the grievance along with the practitioner's history of grievances. The investigation plan may include contacting the provider and conducting an interview about the provider's general practices so long as the issues under investigation do not reveal the identity of the enrollee/complainant. In instances where the enrollee's allegations may be adequately investigated by reviewing the medical record alone, USBHPC will request those medical records without advising the practitioner that the review stems from an enrollee grievance.

In cases where the complaint issue is specific to the enrollee and the provider has no history of similar complaints, options are reviewed with the Optum Medical Director to determine next steps. USBHPC makes every effort to honor the wish of the complainant to remain anonymous.

In either case described above, USBHPC investigates quality of care grievances to the fullest extent possible and works with its network providers to improve care when deficiencies are identified. Additionally, USBHPC continually monitors quality of care grievances – whether or not submitted anonymously – to ensure care is being delivered in accordance with professionally recognized standards of practice to all its enrollees. .

In the specific case audited by the Department and cited within USBHPC's report as referenced above, USBHPC adequately investigated the matter to the fullest extent possible.

USBHPC respectfully disputes the violation that Optum limited its investigation in PQI file #5. A thorough review of the facility's prior complaint history was completed, and no trends or issues were identified that were relevant to this enrollee's grievance, as documented in PQI file #5. The OHBS-CA Medical Director and Quality Review Chair, Joan Odom MD, was consulted on this case for direction, and the medical record was requested based on her review in lieu of calling to ask questions to the facility as member's mother requested to remain anonymous. As noted in PQI file #5, the enrollee's medical record for this episode of care was reviewed with Dr. Odom.

> "Per Dr. Odom, based upon the records received, there are no actionable QoC concerns in this case. The records describe the patient's admission as voluntary, and documentation indicates this was explained to the parent. During treatment, the member expressed suicidal ideation and intent to self—harm. It cannot be substantiated if the member's statements to this effect were because she was coached to say this by peers rather than having a clinical need for treatment. Based upon the member's statements as documented, it is not unreasonable that she remained hospitalized. In addition, because she was not on an involuntary hold, her parents could have requested her discharge. Because inpatient units consist of people who are experiencing mental health issues, adolescent patients can unfortunately be exposed to inappropriate discussions and behaviors despite the level of supervision provided. This does not rise to the level of an actionable QoC concern."

The documentation cited in the violation, "The complainant requested to remain anonymous, so the facility could not be asked specific questions related to these allegations. Therefore, the case may be closed with no further action needed and a QoC rating of 0 – no QoC concern identified " was not to indicate that a full investigation was not completed, rather simply to document that a call was not made to the facility. Because the medical records were obtained, a full investigation was completed, and Dr. Odom's determination was based on the medical record review.

In addition, USBHPC has revised 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. Please see attached evidence of updated workflow and staff training:

- Violation 3_ Anonymous CA KK Complaints Investigation Workflow
- Violation 3_PQI Staff Training_Meeting_Redacted

No further responsive Corrective Action Plan is provided by USBHPC/OptumHealth for Violation #3.