DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

SHARP HEALTH PLAN

JANUARY 4, 2024

Behavioral Health Investigation
Sharp Health Plan
January 4, 2024

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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 (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California law 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 Sharp Health Plan (Plan) is included in Phase Two.

On June 6, 2022, the Department notified the Plan of its BHI covering the time period of April 1, 2020 through May 31, 2022. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan and its Pharmacy Benefit Manager (PBM), CVS Health, on October 12 and 13, 2022.

The BHI uncovered the following six Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Quality Assurance, and Grievances and Appeals:

1. The Plan failed to ensure after-hours emergent and urgent information was provided to all enrollees. Additionally, the Plan is operating at variance with its filed Accessibility policy.
2. The Plan failed to perform oversight of its behavioral health providers to ensure triage and screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage and screening waiting time does not exceed 30 minutes.
3. Failure to ensure quality of care is being reviewed, problems identified, and effective action taken to improve care where deficiencies are identified.
4. Failure to document follow-up when quality of care issues are identified.
5. Failure of customer service to identify all grievances.
6. Failure to identify and log exempt grievances as required.

[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 three barriers to care not based on Knox-Keene Act requirements in the areas of Pharmacy, Cultural Competency, Health Equity and Language Assistance, and Enrollee and Provider Experience:

1. The Plan does not have a policy to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy.
2. 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.
3. Member experience surveys and phone calls to the Plan indicate enrollees have difficulty obtaining behavioral health services.

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 Knox-Keene Act 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. In its Phase Two Summary Report, the Department will provide recommendations for the barriers to care not related to 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 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 analysis 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, 2020, through May 31, 2022, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and Pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

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

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

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan BHI, the Department interviewed one provider in May 2022, whose input was considered for the Plan's BHI. Despite the Department's attempt to engage Plan enrollees, the Department received no response from Plan enrollees willing to be interviewed. The one provider who was interviewed serves San Diego County and stated they never had any issues with Sharp's authorization process, finding the Plan's response to requests for authorizations to be both timely and requests consistently approved.

PLAN BACKGROUND

Sharp Health Plan obtained its Knox-Keene license in 1992 and is headquartered in San Diego. The Plan's parent company is Sharp HealthCare, a San Diego based integrated delivery system that includes independent practice associations (IPAs), independent physicians, hospitals, and ancillary providers. The Plan is a full-service health care service plan licensed to provide managed care health plans to large groups, small groups, individual and family plans, both Covered California and direct, and Medicare Advantage plans. The managed care plans include health maintenance organizations, including Health Savings Account (HSA) compatible high deductible plans and point-of-service plans. As of March 31, 2022, the Plan had 138,931[6] enrollees in its commercial lines of business. The Plan operates in San Diego and South Riverside Counties.

[6] Source: DMHC Dashboard 2022 Q1

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: <u>The Plan failed to ensure after-hours emergent and urgent information was provided to all enrollees. Additionally, the Plan is operating at variance with its filed Accessibility policy.</u>

Statutory/Regulatory Reference(s): Section 1386(b)(1), Rule 1300.67.2.2 (c)(8)(B)(i)

Supporting Documentation:

- Plan's *Accessibility of Services for Primary Care, Behavioral Health Care and Member Services* policy and procedure (March 25, 2020; March 30, 2022)
- Plan document "Sharp Health Plan Section ID: BHIAA3_5" (undated)

Assessment: Health plans that arrange to provide telephone triage or screening services through its contracted primary care and behavioral health providers must require the providers to have a procedure for, among other things, providing specific information to enrollees who call the provider after-hours. The providers must have either a telephone answering machine, telephone answering service and/or office staff to inform the caller:

- The length of time the caller will wait to receive a return call from the provider, and,
- How the caller may obtain urgent or emergency care.[7]

The Plan's *Accessibility of Services for Primary Care, Behavioral Health Care and Member Services* policy (Policy) defines "triage or screening" as:

> The assessment of a Member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage a Member who may need care, to determine the urgency of the Member's need for care.

The Policy states that provider agreements require Plan providers to provide or arrange for the provision of 24/7 triage or screening services by telephone. This triage or screening includes 24/7 employment of a telephone answering machine/service/or office staff to inform callers about the wait time for a return call from the Provider (not to exceed 30 minutes), and how the caller may obtain urgent or emergency care.

The Policy sets a target rate of 100% for behavioral health urgent and emergent after-hours telephone access. With respect to after-hours behavioral health care, the Policy states:

[7] Rule 1300.67.2.2(c)(8)(B)(1) (subsequently revised to Rule 1300.67.2.2(c)(8)(B)(i)).

> The Plan requires primary care physicians and [behavioral health] practitioners to make provisions so that assigned members have access to urgent and emergency care 24 hours a day, seven days a week. Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. After receiving emergency instructions, callers with non-emergency situations who cannot wait until the next business day should receive options to speak with the provider, an on-call provider or a health care professional such as an advice nurse.

The policy provides additional details regarding the required emergency instructions and non-emergency options to speak with a provider.

The Plan reported the results of its 2020 and 2021 after-hours care telephonic survey, which included assessment of compliance with after-hours messaging.[8] The Plan did not meet its 100% target goal in either year, with a compliance rate of 31% in 2020 and 59% in 2021. The Plan did not include separate compliance rates for providing required urgent or emergency information. Because the Plan failed to ensure all enrollees were provided with required after-hours urgent care and emergency information, the Plan failed to comply with Rule 1300.67.2.2(c)(8)(B)(i).

Additionally, health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with its published plan, or in any manner contrary to that described in, and reasonably inferred from the plan as contained in its application for licensure, or any modification thereof.[9]

The Plan filed its *Accessibility of Services for Primary Care, Behavioral Health Care and Member Services* policy with the Department.[10] Because the Plan did not meet the Policy's stated target rate of 100% for providing after-hours care, the Plan was operating at variance with its filed Policy.

Conclusion: Because the Plan failed to ensure after-hours emergent and urgent information was provided to all enrollees, the Department finds the Plan in violation of Rule 1300.67.2.2(c)(8)(B)(i). Additionally, the Department finds the Plan operated at variance in violation of Section 1386(b)(1) because the Plan failed to achieve its internal compliance rate for providing urgent and emergency after-hours call information as stated in its policy on file with the Department.

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[8] In response to the Department's request for documents demonstrating corrective actions taken by the Plan or its delegate in response to internal monitoring of timely access, geographical access and grievances involving behavioral health services, the Plan submitted the Section ID: BHIAA3_5 document.
[9] Section 1386(b)(1).
[10] See eFiling # 20191121 and # 20201114.

QUALITY ASSURANCE

#2: <u>The Plan failed to perform oversight of its behavioral health providers to ensure triage and screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage and screening waiting time does not exceed 30 minutes.</u>

Statutory/Regulatory Reference(s): Rules 1300.67.2.2(c)(8)(A) and (B)

Supporting Documentation:

- Provider Appointment Availability Survey (PAAS) results (2020, 2021)

Assessment: In addition to providing after-hours urgent and emergent information as described in violation #1 above, health plans must ensure telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition and that the wait time does not exceed 30 minutes.[11]

The Department requested copies of reports, documents and completed tools used to track and evaluate triage or screening wait times. As a response, the Plan provided its 2020 and 2021 Provider Appointment Availability Survey (PAAS) results, which do not include information on triage and screening wait times. The Department requested reports addressing the requirement for triage and screening wait times to not exceed 30 minutes. The Plan responded that triage and screening is performed by its contracted providers. The Plan also stated it does not assess or triage enrollees. The Department sent a follow-up inquiry on the matter to which the Plan responded:

> The UM department does not have triage and screening reports. Plan members have direct access to behavioral health providers. Behavioral health providers provide screening for members. Members also have direct access to Emergency Rooms, to psychiatric hospitals such as Sharp Mesa Vista, and to outpatient providers. Emergency admissions do not require prior authorization and are directly admitted. Members who go to the emergency room receive a post ER follow up call from the UM nurse case manager to ensure they have discharge instructions, medications, and follow up appointments.

The Plan was unable to provide evidence that it has a process, documentation or reports reflecting oversight of triage and screening as required by Rule 1300.67.2.2(c)(8)(A).

Conclusion: The Department finds the Plan in violation of Rule 1300.67.2.2(c)(8)(A) for failure to ensure triage or screening services are provided in a timely manner

[11] Rule 1300.67.2.2(c)(8)(A).

appropriate for the enrollee's condition and that the wait time does not exceed 30 minutes.

#3: <u>Failure to ensure quality of care is being reviewed, problems identified, and effective action taken to improve care where deficiencies are identified</u>.

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1) and (a)(3)

Supporting Documentation:

- Plan's Log C (inquiries)

Assessment: Health plans must have quality assurance programs that document the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.[12] Additionally, the quality assurance program must address service elements, including accessibility, availability, and continuity of care. A plan's quality assurance program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.[13]

The Department determined that the Plan's customer service representatives do not identify, document and refer all enrollee grievances for handling. Because the Plan does not identify and document all grievances, the Plan is unable to review all quality of care and quality of service issues raised in those grievances. The unidentified quality of care and quality of service issues are not documented or investigated, and the Plan is unable to take effective action to improve care and plan follow up where there are quality deficiencies.

Notes documented in the Plan's Inquiry Log (Log C) included several enrollee grievances that raised quality of care and quality of service concerns: Several enrollees called for assistance in finding a provider and described having poor experiences with a contracted provider group, some stated they received little help from the provider group and some described the behavioral health provider group as "horrible," "terrible" or "bad."[14] Some enrollees complained they needed in-person visits but the provider group was only offering telehealth visits,[15] suggesting a telehealth-only provider group does not ensure quality of care for all enrollees. Numerous enrollees called the Plan stating they contacted one or both of the Plan's contracted behavioral health provider groups

[12] Rule 1300.70(a)(1).
[13] Rule 1300.70(a)(3).
[14] See Log C, Plan ID #s 867102, 809922, 1389609, 1311081, 1245928, 963861, 1122343, 999835, 999835, 1220371.
[15] See Log C, Plan ID #s 837483, 1446889, 1111846, 1420056

and no appointments were available for two or more months, and in some cases, several months.[16]

Examples:

1. An enrollee called the Plan in need of in-home Applied Behavior Analysis therapy services for the enrollee's autistic child. The enrollee stated the Plan's contracted behavioral health provider group is only offering telehealth and the child needs the presence of the provider to participate.[17]
2. An enrollee called the Plan in July 2021 asking how to make a mental health appointment with a LGBTQ provider. The Plan's customer service representative contacted Psychiatric Centers of San Diego (PCSD), one of the Plan's contracted behavioral health provider groups, but found that PCSD's "only provider available with LGBTQ [was] fully booked until December."[18]
3. An enrollee called the Plan in January 2021 and stated, "I'm reaching out to you because I've had some really bad experiences with PCSD. Their customer service wasn't great before COVID, but now it's unbearable."[19]
4. An enrollee in need of substance use disorder services, who had been discharged from a substance use disorder facility ten days prior called the Plan on several occasions stating they felt they were discharged from care too early and needed help. The enrollee stated they contacted a provider group for an appointment, but was told they had no beds available and no telehealth appointments for three months. The enrollee acknowledged during one call with the Plan that the enrollee was intoxicated and expressed suicidal ideations to the customer service representative. [20] The Plan's claim log shows the next claim for services provided to this enrollee was for a telehealth visit one month after the enrollee's phone calls to the Plan.[21]
5. An enrollee called the Plan on a Wednesday at 12:40 p.m., stating they were having an anxiety attack. The customer service agent attempted to conference call one of the contracted behavioral health provider groups to provide immediate assistance to the enrollee, but noted "however, they are closed from 12-1 pm for lunch."[22] The enrollee said they would try to call them back on their own at 1:00 p.m.

These examples demonstrate potential quality of service and quality of care issues. However, there is no evidence any of these cases, or any other cases on the Plan's Log

[16] See, e.g., Log C, Plan ID #s 1379007, 1051897, 1163554, 1277027, 1057763, 1453523, 1413409, 1346125, 983626, 1105532, 1440420, 1081847, 952089, 1297113, 1118677, 1468916, 952090, 1254853, 837743, 1147938, 1010407, 1243292, 1348366, 1080162, 1222050, 1019810, 979934, 1064798, 1363131, 1410231, 1159636, 1385694, 1224891, 1348283, 1337865.
[17] See Log C, Plan ID #837483.
[18] See Log C, Plan ID #1190878. PCSD is now part of Mindpath Health. Through the Plan's other behavioral health provider group, Lifestance, the enrollee obtained an appointment the following month.
[19] See Log C, Plan ID #991831
[20] See Log C, Plan ID #s 1307557, 1309892, 1310489, 1311282, 1313577.
[21] See Log H, Claim #20210304000061
[22] See Log C, Plan ID #931293

C that contained potential quality issues (PQIs), were referred for quality assurance review and investigation. Health plans are required to review, document and identify quality of care issues and have quality assurance programs to address service elements, including accessibility, availability, and continuity of care.[23]

Conclusion: The Department identified numerous instances of PQIs in the Plan's inquiry Log C with no evidence the issues were referred for grievance or quality handling. By not identifying and processing all PQIs, and failing to address all quality issues, the Plan is in violation of Rules 1300.70(a)(1) and (a)(3).

#4: Failure to document follow-up when quality of care issues are identified. Additionally, the Plan is operating at variance with its filed Potential Quality of Care Issues policy.

Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(1) and 1300.70(b)(1)(A) and (B)

Supporting Documentation:

- Plan *Identification of Potential Quality of Care Issues* policy (September 29, 2021)
- Five Potential Quality Issue files (April 1, 2020 – May 31, 2022)
- Plan Peer Review Committee minutes (February 16, 2022)
- Plan *Peer Review Acuity Levels*

Assessment: Based on review of the Plan's PQI files and interviews conducted with Plan staff, the Department found the Plan does not consistently follow-up to ensure corrective action plans (CAP) are effective.

Section 1370 requires plans to "establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs." Rule 1300.70(a)(1) requires plans to "document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated." Rule 1300.70(b)(1)(A) and (B) require health plans to "continuously review the quality of care provided," ensure "a level of care which meets professionally recognized standards of practice is being delivered to all enrollees," and ensure that "quality of care problems are identified and corrected for all provider entities." While the Plan opened a prompt investigation of referred PQIs, there was no documented evidence the Plan conducted follow-up to confirm or evaluate corrective action.

[23] Rules 1300.70(a)(1), (a)(3)

The Plan's *Identification of Potential Quality of Care Issues* policy requires documentation by the Plan's Peer Review Committee of PQI information, including resolution of PQIs and follow-up concerning CAPs, among other things.

The Plan identified a total of five PQIs during the investigation period of April 1, 2020 through May 31, 2022. Of the five files, one file involved a confirmed quality issue for which a CAP was formulated. The file did not include documentation of Plan follow-up or evaluation of CAP implementation, monitoring, or completion.

Case File #5 This file involved an attempted suicide by an enrollee during a stay in a psychiatric hospital. The Plan investigated the issue, requested the enrollee's medical records and a response from the provider, as well as corrective action. The provider provided a prompt response along with a statement of corrective action taken, as well as future corrective action to ensure safety of enrollees admitted under similar clinical circumstances. The Plan's Peer Review Committee reviewed the matter, assigned a severity level to the quality issue and documented that it would refer the matter for additional quality review by a behavioral health hospital.

Although the Plan conducted an investigation and identified the quality issue, there was no indication of any follow-up activity to evaluate or audit the status of the corrective actions, whether corrective actions were fully implemented, whether policy changes were made at the facility, or whether the corrective action was likely to prevent future similar events. Given the gravity of the quality issue and the Plan's policy requirements, follow-up by the Plan was warranted.

Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with its published plan, or in any manner contrary to that described in, and reasonably inferred from the plan as contained in its application for licensure, or any modification thereof.[24]

The Plan filed its *Identification of Potential Quality of Care Issues* policy with the Department.[25] Because the Plan did not document follow-up concerning the CAP, the Plan was operating at variance with its filed Policy.

Conclusion: Section 1370 requires the Plan to continuously review quality of care, including performance of medical personnel. Rule 1300.70(a)(1) requires the Plan document that quality of care provided is reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Department determined the Plan does not consistently document that it assesses CAPs or implements follow-up when indicated to ensure that formulated CAPs were effective to improve the quality of care. Additionally, the Department finds the Plan operated at variance in violation of Section 1386(b)(1)

[24] Section 1386(b)(1).
[25] See eFiling #20201158.

because the Plan failed to document follow-up of its corrective actions. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

GRIEVANCES AND APPEALS

#5: <u>Failure of customer service to identify all grievances.</u>

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rules 1300.68(a)(1), (a)(2)

Supporting Documentation:
- Plan's Log C (inquiries)
- Plan's Log F (grievances and appeals)
- Plan *Member Grievances* policy (January 1, 2021)

Assessment: Review of Plan data demonstrated the Plan does not identify and process all grievances as required.

The Department requested the Plan submit a log, identified as "Log C" to include "data from all enrollee (or enrollee's representative) contacts received during the review period that pertain to behavioral health services, and which ***did not result in processing the call as a grievance***." (emphasis in original). Log C was to include specifically requested data including, among other things, a summary of the issue and/or reason for the call, and a summary of the resolution. The Department also requested the Plan submit a log, identified as "Log F" to include "all grievances that involve or are related to behavioral health services, including: "all grievances that involve or are related to behavioral health services, including, but not limited to, treatment type, treatment duration, behavioral health prescription drugs, grievances about a provider or the Plan/Delegate, appeal of denied or modified services, delayed appointments, etc."

The Department found the Log C contained grievances Plan customer service representatives failed to identify and/or refer for grievance handling. Health plans must have procedures to ensure adequate consideration and rectification of grievances, and ensure grievances are reviewed and resolved timely.[26] 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[27]." Rule 1300.68(a)(2) states a "complaint" is the same as a grievance. The Plan's grievance and appeals policies and procedures include definitions that conflict with the Knox-Keene Act definition of grievance.

The Plan's *Member Grievances* policy states, in part: "The Grievance process begins when a Member submits a verbal or written request for a Grievance to the Plan." The

[26] Section 1368(a)(1)
[27] Rule 1300.68(a)(1)

Plan's Log C data indicates when enrollees expressed dissatisfaction with the Plan or a Plan provider, or complained about services or wait time for appointments, or disputed coverage or bills for services, the Plan's customer service representatives did not consistently identify and document the enrollee's grievance. In several cases, the customer service representative responded to the enrollee's complaint, expression of dissatisfaction or other grievance by informing the enrollee they could submit a grievance, or offered to submit a grievance for the enrollee. In some instances, even when a customer service representative stated they would file a grievance on behalf the enrollee, there is no evidence indicating the grievance was filed.

Examples:

1. An enrollee called the Plan about a bill received for services. The services involved multiple, separate visits and the enrollee was charged a separate copay for each visit. The enrollee disputed the charges, stating they were assured by the provider's office personnel that the services were 100% covered. The customer service representative suggested the enrollee contact the provider's office to obtain specific details and allow the facility to try to rectify the situation and if the provider would not rectify the situation, the enrollee could call the Plan back to grieve or appeal the charges. Log F does not include this enrollee's complaint, indicating the customer service representative did not document or refer the enrollee's coverage dispute grievance for handling.[28]
2. An enrollee's parent telephoned the Plan seeking help finding Attention Deficit Hyperactivity Disorder testing and stated they "refuse to go to PCSD as he has gone in the past and has had horrible experience and has been treated so poorly." The customer service representative documented "To avoid the grievance, I offered to submit for an out-of-network" provider.[29] Not only does Log F not include this enrollee's complaint, the Plan's log for out-of-network requests (Log M) also includes no record of request for out-of-network services for this enrollee.
3. An enrollee called the Plan and complained they were hung up on four times in one day, a Plan representative gave them incorrect behavioral health benefits information and the Plan's behavioral health contracted provider group PCSD "gave her a date too far in the future to deal with her issue." The enrollee also stated they were provided with conflicting information about whether a referral was needed to see a behavioral health provider. The customer service representative documented "Member didn't want to file a grievance at this time" but would review the matter with a supervisor. Log F does not include this enrollee's grievances, indicating the customer service representative did not document or refer the quality of service or access grievances for handling.[30]

[28] See Log C, Plan ID #791887.
[29] See Log C, Plan ID #1245928.
[30] See Log C, Plan ID #785656.

4. An enrollee called the Plan stating they had been to a particular provider office and was "horrified and dismayed" with the experience, stating they were exposed to racial slurs and had to wait two hours for the appointment. The customer service representative documented they would be filing a grievance on behalf of the enrollee. Log F does not include this enrollee's quality of service grievance, indicating the customer service representative did not file the grievance as promised.[31]
5. An enrollee's parent called the plan stating the Plan's contracted medical group had no available appointments for three months. The customer service representative documented showing the parent where to find a list of mental health providers on the Plan's website and advised the enrollee they could submit a grievance on the parent's behalf, or the parent could submit a grievance.[32]

Although these calls to the Plan involved expressions of dissatisfaction with the Plan or providers, delayed service problems, or disputed charges, none of these calls were identified or handled by the Plan as grievances, in violation of Rule 1300.68(a).

Section 1368(a) requires plans to have reasonable procedures in accordance with Department regulations to ensure adequate consideration and rectification of grievances. In accordance with the definition of "grievance" in Rule 1300.68(a)(1), the written or oral expression of dissatisfaction itself, or the expression of a quality of care concern, the complaint, the dispute or the request for consideration or appeal ***is the submission of the grievance to the health plan***. The Knox-Keene Act does not require enrollees (or their designated representatives or their providers, on their behalf) to use any specific words in order to submit a grievance to a health plan, nor does the Knox-Keene Act include an exception when enrollees decline a grievance when asked. Contrary to the Plan's policy, enrollees need not specifically request a grievance. Rule 1300.68(a)(1) specifically indicates that in instances of uncertainty, when a health plan is unable to distinguish between an inquiry and a grievance, the health plan is to deem the communication a grievance.

By failing to identify and process enrollee grievances, the Plan is unable to track and trend problems, adequately consider or rectify problems, ensure the quality of care and quality of services or provide a resolution to enrollees as required. Furthermore, by recommending enrollees call providers in attempts to rectify problems, or search on the Plan's website for providers when the enrollee states they have been unable to find an appointment, or otherwise require enrollees to address their own grievances, the Plan attempts to shift its obligation under the Knox-Keene Act to receive, review and resolve grievances.

Conclusion: The Plan's customer service representatives failed to identify enrollee calls as grievances although they involved expressions of dissatisfaction with providers

[31] See Log C, Plan ID #867115.
[32] See Log C, Plan ID #920525.

or the Plan, among other things. Failure to identify and process grievances hinders a health plan's ability to accurately track and trend grievances, identify patterns and timely correct problems. Additionally, enrollees are denied certain rights, such as adequate consideration of their grievance and the receipt of acknowledgement and/or resolution letters describing any investigation and outcome of the grievance, and appeals rights, when applicable. The Department therefore determined the Plan is in violation of Section 1368(a)(1) and Rule 1300.68(a).

#6: <u>Failure to identify and log exempt grievances as required.</u>

Statutory/Regulatory Reference(s): Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8)

Supporting Documentation:

- Plan's Log C (inquiries)
- Plan's Log F (grievances and appeals)
- Plan *Member Grievances* policy (January 1, 2021)

Assessment: Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) impose specific requirements for certain grievances received by health plans. These requirements include the following:

> Grievances received by telephone, by facsimile, by email, or online through the health plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5) [which require health plans to send the enrollee an acknowledgement letter and a resolution letter]. The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
>
> (I) The date of the call.
> (II) The name of the complainant.
> (III) The complainant's member identification number.
> (IV) The nature of the grievance.
> (V) The nature of the resolution.
> (VI) The name of the plan representative who took the call and resolved the grievance.

Grievances covered by Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8) may generally be referred to as "exempt" grievances because they are exempt from the written acknowledgement and resolution requirements. The Plan's Log F was to include all grievances, including exempt grievances.

Of the 161 grievance entries on Log F, the Plan identified 154 as standard grievances and the remaining seven as expedited grievances. During interviews, the Department questioned the Plan about having zero exempt grievances on its Log F. The Plan responded, "The exempt grievance process is new to Sharp, in the past we did not have them, but we recently started, so the current volume is low [and] for the behavioral health review period, we did not have any." The Plan stated they began an exempt grievance process in 2020.

As described in violation # 5 above, the Department identified grievances in the Plan's Log C data which the Plan did not identify or process as grievances. Similarly, the Department identified grievances in the Plan's Log C that should have been documented and tracked as exempt grievances consistent with Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8).

Examples:

1. An enrollee called the Plan stating they were dissatisfied with the fact that the Plan does not cover marriage counseling and that for individual therapy, the enrollee had to wait several weeks between appointments because PCSD has only one provider who offers the treatment type the enrollee was receiving. The Plan's customer service representative advised the enrollee how they could file a grievance, provided the Plan's website information, and marked the call as resolved on the same day it was received.[33]
2. An enrollee called the Plan stating they had a bad experience with a Plan provider who would not fill out and complete the enrollee's bariatric clearance letter. The Plan's customer service representative asked whether the enrollee wanted to submit a grievance and provided other provider search resources to the enrollee. The customer service representative marked the call as resolved on the same day it was received.[34]
3. An enrollee's parent called the Plan to request an out-of-network provider referral for their child stating they "went through PCSD in the past and . . . will never go back because they were terrible." The Plan's customer service representative apologized and stated she completed an out-of-network request on the enrollee's behalf. The customer service representative marked the call as resolved on the same day it was received.[35]
4. An enrollee called the Plan upset that the number on the back of the enrollee's health plan membership card directed them to the Plan and not a mental health provider. The customer service representative marked the call as resolved on the same day it was received.[36]

These examples, in addition to the grievance examples described in items 2, 4 and 5 in violation # 5 above, are examples of Log C entries for which the Plan's customer

[33] See Log C, Plan ID #1227850.
[34] See Log C, Plan ID #1398614.
[35] See Log C, Plan ID # 1122343.
[36] See Log C, Plan ID #1138527.

service representative marked the call as resolved on the same day it was received. Because each of these items involved an expression of dissatisfaction about the Plan or a provider that was not a coverage dispute, a disputed health care service involving medical necessity, or experimental or investigational treatment, and because the issues were resolved by the next business day, or the same day in these cases, the calls met the criteria of exempt grievance. However, none of these grievances were identified and documented as required by Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8).

Conclusion: The Plan stated it did not identify any exempt grievances for the BHI review period. However, review of the Plan's Log C inquiry data showed enrollees submitted grievances to the Plan that met the criteria of exempt grievance, but none were identified or processed as exempt grievances. Therefore, the Department finds the Plan in violation of Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8).

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

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

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

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

#1: <u>The Plan does not have a policy to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy.</u>

Summary: When asked to provide a copy of the Plan's medical policy to provide Medication Assisted Treatment (MAT), which is delivered in two ways, Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy, and a copy of the Plan's medical policy for the OTPs and OBOT waiver program physicians, the Plan acknowledged it had no policies or other documents responsive to the request.

During interviews, the Plan stated it has had discussions with Plan physicians but acknowledged it is difficult to encourage primary care physicians (PCPs) to obtain the federal MAT prescribing waiver required to administer MAT, as PCPs frequently report being overburdened by the more typical duties of primary care medicine.

Office-based settings are generally more accessible to enrollees and hold less social stigma as compared to formal treatment program settings. Limiting the availability of MAT services to locations other than office-based settings is likely to reduce accessibility of these services to enrollees who would benefit from having these services provided in a more familiar, comfortable setting.

#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 and gender identity, income level and geographic location.</u>

Summary: The Department requested Plan documents describing processes for identifying disparities across the enrollee population for age, race, culture, ethnicity, sexual orientation and gender identity, income level and geographic location. The Department also requested documents demonstrating Plan activities to monitor and address those disparities, and policies and procedures describing Plan community outreach and engagement with identified racial, cultural, linguistic, and smaller populated cultural communities.

In response to the Department's request, the Plan provided a copy of its *Language Assistance Program* which describes assessment of enrollee language preferences and provision of language assistance services. The Plan also provided a copy of its 2021 *Cultural and Linguistic Assessment* document which sets forth data pertaining to enrollee race, ethnicity, languages spoken and religious preferences in addition to languages spoken by Plan providers. Finally, the Plan submitted a narrative response which stated, in part:

> The Plan currently collects information on disparities across its enrollee population accessing behavioral health services. The Plan utilizes health information technology services on data such as sex at birth, gender identity, race/ethnicity, language, disability, geographic location, cultural, and linguistic needs. The plan does track key disabilities but does not use them in disparity analysis.

Although the Plan's response and documents address language assistance requirements and demonstrate some collection of cultural data, the documents do not demonstrate the Plan's process for evaluating and addressing disparities in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation and gender identity, income level or geographic location. Additionally, the Plan stated it has no policy or procedure describing community outreach and engagement with identified racial, cultural, linguistic, and smaller populated cultural communities. While the Plan indicated it participated in community events and outreach involving community-based programs, no supporting documentation was provided.

Finally, the Plan was unable to provide documents describing oversight and monitoring of its contracted providers to ensure providers meet the cultural, ethnic, racial, and linguistic needs and preferences of its membership. The Plan was unable to demonstrate it has a strategy to identify and address cultural disparities across its enrollee population, and therefore is unable to assess whether enrollee cultural needs are met.

#3: <u>Member experience surveys and phone calls to the Plan indicate enrollees have difficulty obtaining behavioral health services</u>.

Summary: Health Plans are required to conduct an annual enrollee experience survey designed to assess compliance with timely access standards. [37] In 2021, the Plan utilized the Experience of Care and Health Outcomes (ECHO) survey with the objective to "assess the quality of behavioral health services by focusing on the patient's experiences with care." Based on the responses of 312 completed enrollee surveys, the report identified three metrics as having opportunity for improvement:

- Ease of getting the treatment you thought you needed,
- Satisfaction with the range of available services, and
- Ease of getting [a provider] you are happy with.[38]

The Plan's enrollee survey results reflect the opinion among enrollees that it is not easy to get treatment or a provider with whom the enrollee is happy, and enrollees are not satisfied with the range of available behavioral health services.

The Plan provided a list of out-of-network requests for the review period, which showed 607 enrollee requests for services from out-of-network providers, including 386 (64%) approvals, 220 (36%) denials and one modification. The Department reviewed 30 files involving requests for behavioral health services from out-of-network providers. Of the 30 files, 24 involved authorizations. Of the 24 authorizations, eight (30%) were approved based on insufficient timely access to in-network providers. These results suggest enrollees attempting to obtain behavioral health services from network providers experience challenges obtaining timely appointments requiring enrollees to seek out-of-network care. These file review results are consistent with the enrollee experience survey findings indicating enrollees face difficulties when trying to get needed care.

Additionally, review of the Plan's Log C inquiry data demonstrated numerous instances in which enrollees called the Plan for assistance with behavioral health issues and expressed frustration and less than satisfactory experiences, such as difficulty or inability to get an appointment, trouble with processes for getting an appointment, negative prior experiences with care received from one or both Plan contracted behavioral health groups, receipt of unexpected bills for behavioral health services or other coverage or service issues, for example.[39] The Plan's documented notes demonstrate enrollees experienced difficulty with Plan and provider processes for obtaining appropriate, suitable behavioral health services.

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[37] Rule 1300.67.2.2(d)(2)(B).
[38] ECHO – Adult Member Research, 2021 Results, page 3.
[39] See, for example, Log C Plan File ID #s 785656, 791887, 814701, 827277, 867115, 905390, 924420, 944604, 963861, 984943, 991831, 999835, 1096381, 1103622, 1121896, 1123669, 1129531, 1138527, 1140145, 1154842,1160454,1209754, 1220371, 1227765, 1233814, 1245928, 1285539, 1302843, 1309892, 1311081, 1389609, 1398614, 1399466, 1420056, 1446894, 1449982, 1462052.

Examples:

- An enrollee called the Plan stating they called a contracted facility for substance use disorder services, but was told they must "…call every day to see if a bed is available." The enrollee became upset during the call when the Plan's customer service representative suggested the enrollee "to continue to call" the facility. The enrollee stated they expected to receive assistance from the Plan.[40]
- An enrollee called the Plan stating they wanted to set up an appointment, but could not get through to the Plan's behavioral health provider group.[41]
- An enrollee called the Plan stating their spouse had been admitted to an out-of-network facility on a 72-hour hold and they needed to be transferred to a contracted facility. The enrollee stated they had "been calling around back and forth and has not gotten any assistance."[42]
- An enrollee called the Plan stating they needed in-person appointments, but the Plan's two contracted behavioral health groups were only offering telehealth services.[43]

The enrollee experience survey results, along with enrollee phone calls to the Plan, demonstrate enrollees experienced a variety of barriers, delays and difficulties in obtaining behavioral health services.

[40] Log C Plan File ID #905390
[41] Log C Plan File ID #984943
[42] Log C Plan File ID # 1129531
[43] Log C Plan File ID # 1420056

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

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

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

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

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

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

The Plan may submit a statement describing actions the Plan has or will take to address the three barriers to care not based on Knox-Keene Act requirements (Barriers Statement). This separate Barriers Statement is **not** part of the corrective action plan described below, and should be submitted separately. Should the Plan wish to submit a Barriers Statement, please submit it to the Department no later than February 3, 2024, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, and CAP via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps shown below to view and submit the documents required:

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

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

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

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

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: SHARP HEALTH PLAN	
Cary Shames, DO	Chief Medical Officer
Lisa Arian, MD	Senior Medical Director
Robert Friedman, MD	Behavioral Health Medical Director
Bahareh Khavarian, MD	Medical Director
Andres Aguirre	Director of Quality Improvement
Jason Smith	Director, Operations & Performance Improvement
Ruth Donaldson, RN	Director, Population Health & Medical Management
Annette Esparza, RN	Manager, Utilization & Care Management
Yolanda Hunt-Boes	Manager, Network Management & Application Optimization
Neville Tarapore	Health Services Data Analyst
Olivia Meredith	Manager, Customer Care
Takeisha Randolph	Supervisor, Appeals & Grievances
Tammy Rollins	Manager, Claims Administration
Brett Guglielmetti	Manager, EDI Management
Greg Limon	Director, Revenue Cycle and Data Management
Julie Misleh	Supervisor, Billing
Paul Piche	Director, Finance
Darcie Paz	Contracts Manager
Zachary Contreras, PharmD	Director, Pharmacy Benefits
Kate Tepedino, PharmD	Manager, Pharmacy Benefits
Leslie Pels-Beck	Vice President, Chief Operations Officer
Ryan Mooney	Director, Compliance/Regulatory Affairs
Erica Graham	Manager, Legislative & Regulatory Affairs
Khanh Shafer	Lead, Compliance Monitoring/Oversight
Naomi Casiano	Appeals/Grievances Coordinator
Gabriel Sanchez	Customer Care Specialist
Patrice Jett	Customer Care Specialist

DELEGATE STAFF INTERVIEWED FROM: CVS HEALTH	
Marcus Grayson	Account Executive
Olivia Singer	Account Manager
Melody Chien, PharmD	Clinical Advisor
Kristina Allen	Senior Manager
Tiffany Keppy	Manager
Marcus Bulow	Manager/Lead
Penny Barnes	Lead Director Client Ops
Dianne Renner, PharmD	Clinical Pharmacist
Kishan Raval, PharmD	Manager Pharmacy Operations
Sujeet Navale, PharmD	Clinical Advisor
Mindy Messina, PharmD	AVP Clinical
Meghan Frey-Branning, PharmD	Senior Manager

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management authorizations, modifications and denials for Behavioral Health Services	30	10059247 10092957 10055112 10083324 10064092 10073121 10090258 10058550 10093422 10076152 10061025 10053924 10061495 10085128 10077223 10054968 10083993 10090509 10075573 10075696 10064926 10077040 10078831 10056599 10087357 10058204 10055794 10067193 10058545 10059154
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Utilization Management authorizations, modifications, and denials of Behavioral Health Services - Rx	30	21-050636272 20-044562834 21-050560490 21-050838409 21-052126851 20-046320820 20-044721110 20-048750729

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management Authorizations, Modifications and Denials of Behavioral Health Services – Rx (continued)		20-048802013 22-060984078 21-053591293 20-045020764 21-049286918 22-059510288 20-046225205 21-052381202 21-055629326 20-047490425 22-060407603 21-049284369 21-053071589 21-053537018 21-051070101 20-044851225 20-047441475 21-052090580 20-046406610 20-045054525 22-057739395 22-057888740
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Benefit/Coverage/ Experimental/ Administrative Denials of Behavioral Health Services	25	10086780 10086632 10085995 10085195 10070524 10069659 10069497 10066805 10066672 10060308 10059949 10059948 10059798 10059470 10058468 10058093 10056690 10056669 10056477 10056360

Type of Case Files Reviewed	# of Files	Case ID Number
Benefit/Coverage/ Experimental/ Administrative Denials of Behavioral Health Services (continued)		10056286 10055869 10055807 10054847 10054396
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Benefit/Coverage/ Experimental/ Administrative Denials of Behavioral Health Services - Rx	30	20-044656477 20-045375695 20-045512437 20-045926374 20-046043999 20-046253880 21-055655957 21-055656237 22-059448992 21-051502146 21-051651320 21-052626372 21-053731961 21-054453718 21-054552281 21-055033034 21-055210715 21-055957622A 21-056059187 22-057374978 22-057491204 20-044742258 20-044851231 20-046278900 20-047954127 20-048622191 20-048627674 21-049078239 21-049265597 21-049304014

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Inquiry Contacts	34	1239810 907222 1373550 779437 1464807 1131903 1128253 1232393 1468135 908479 1109268 1463999 905582 990171 1285426 811599 1299430 906003 833099 1083821 1339906 1089074 836218 938057 1001531 1175653 1378224 980454 1170925 1311857 1168123 1438953 823647 1040874
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issues	5	90027 90032 90034 90039 90042

Type of Case Files Reviewed	# of Files	Case ID Number
Provider Complaints	30	1077492 1384008 1333802 1100987 1122105 1405606 1074853 1101230 1164958 1088621 1039770 1088629 1372987 1164979 1353523 1411234 1064918 1064906 1064949 1064933 1065201 1064794 1064902 1064941 1150985 1150982 1150987 1447865 1164642 1164948
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievances and Appeals	30	25856 22991 29802 25831 30005 28028 21203 28418 22461 COM_APL_2022_000133 23626 25595

Type of Case Files Reviewed	# of Files	Case ID Number
Grievances and Appeals (continued)		23381 25801 25810 26141 29127 30046 21500 29623 25094 22244 30058 COM_GRV_2022_000120 22460 COM_GRV_2022_000435 28469 26287 COM_APL_2022_000331 COM_APL_2022_000039
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievances and Appeals – Rx	33	20-046269345A 22-057252951A 22-058226548A 20-045665288A 21-049284369A 21-051749248A 20-046605665A 21-053800756A 22-059886298A 20-043476005A 22-060804290A 20-045484856A 21-048939627A 21-051836568A 22-060426920A 21-053857284A 21-052716249A 21-052511032A 21-054131238A 21-051190612A 20-045330508A 22-058559109C 20-043890185C 21-055033034A

Type of Case Files Reviewed	# of Files	Case ID Number
Grievances and Appeals – Rx (continued)		20-046583063A 22-057593257A 20-044724583A 20-045628645A 20-046942324A 22-060276817A 20-045036952A 22-058529331A 22-058571961A
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Paid Claims	30	20210308000098 20210429001085 20211029000173 20211201000327 20220121000388 20220207000714 E202008311015784 E202012312149050 E202101142207764 E202104262736758 E202108203344072 E202110043561181 E202111223858926 20200911000416 20211006000014 20220505000656 20220526000403 E202201034058251 E202205024689026 20200527003385 20200630000188 20200911000706 20201127002100 20210416000771 20211012000227 20220426000660 E202009141464249 E202105272875292 20200813000973 20200915000426

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims	30	20210312000372 20211122000570 20220504000447 20200903003181 20220519000457 20210113001768 20220107000404 20220510000019 20200519001058 20210419000482 20210318000111 20210702000817 20220603000826 20210923002907 20211026001207 20210422000863 20220211001667 20210506001764 20210917003197 20210805000469 20210805000596 20220331001170 20210211000453 20220512000864 20220505000461 20210723000565 20210908000194 20211018001070 20220428000251 20201021000768
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Out-of-Network Requests	30	10093696 10093564 10093024 10092818 10092660 10092450 10092322 10091925 10091712 10091562 10091554 10091268

Type of Case Files Reviewed	# of Files	Case ID Number
Out-of-Network Requests (continued)		10091232 10091201 10090831 10090592 10090266 10089718 10089349 10089214 10089088 10088838 10088174 10087357 10087072 10086924 10086450 10085227 10085133 10084835

Sharp Health Plan Corrective Action Plan Response

Sharp Health Plan
DMHC No. 933-0310
February 2, 2024

Sharp Health Plan's Response to the Department of Managed Health Care's Behavioral Health Investigation Report

Sharp Health Plan (Plan) submits the following information in response to the Department of Managed Health Care's (Department's) Behavioral Health Investigation (BHI) of the Plan, dated January 4, 2024. As per the Department's instructions in its BHI Report, where requested in the Department's examination findings, the Plan has provided its response and stated the actions taken to address the findings.

The Department's comments are provided in bold font and the Plan's responses are provided in regular font below.

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan failed to ensure after-hours emergent and urgent information was provided to all enrollees. Additionally, the Plan is operating at variance with its filed Accessibility policy.

Statutory/Regulatory Reference(s): Section 1386(b)(1), Rule 1300.67.2.2 (c)(8)(B)(i)

The Plan respectfully disagrees with the Department's finding that the Plan failed to ensure that after-hours emergent and urgent information was provided to all enrollees. The documentation submitted to the Department was not inclusive of all results of the 2020 and 2021 After-Hours surveys. Only the initial results were shared, and not the final re-survey results, along with project close-out, which shows that surveyed providers who failed the re-survey eventually were brought into compliance.

Compliance actions taken to ensure proper oversight:

- The Plan submits its 2020 and 2021 After-Hours re-survey results as shown in Attachments 1A.1 and 1A.2.
- As of February 1, 2024, the Plan is delegating behavioral health services to Magellan Health. Magellan Health's auto-attendants have an emergency option as the first statement, allowing enrollee emergency calls to be immediately routed to a Customer Experience Associate (CEA) or Care Manager (CM). For rotary callers, voice recognition technology or an auto transfer for non-responses will route callers to a CEA or CM. Magellan Health has live telephonic access via Customer service and clinical staff who are accessible 24 hours a day, seven days a week and 365 days a year.

QUALITY ASSURANCE

#2: The Plan failed to perform oversight of its behavioral health providers to ensure triage and screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage and screening waiting time does not exceed 30 minutes.

Statutory/Regulatory Reference(s): Rules 1300.67.2.2(c)(8)(A) and (B)

The Plan respectfully disagrees with the Department's finding that the Plan failed to perform oversight of behavioral health providers to ensure triage or screening services are provided in a timely manner. The documentation submitted to the Department was not inclusive of all results of the 2020 and 2021 After-Hours surveys. The Plan conducts the After-Hours Survey annually in collaboration with HICE to meet timely access standards for after-hours care, emergent care, triage services and member wait times to connect with a provider. The survey tool provided as documentation details the questions asked to ensure provider compliance with timely access as shown in Attachment 2A. In addition to medical providers, the Plan includes a sample of behavioral health providers. Non-compliant providers are issued a notice of non-compliance as shown in Attachments 2B.1 and 2B.2. The Plan resurveys previously non-compliant providers and if a provider is found to remain non-compliant, then a corrective action plan is imposed. All providers were compliant during the review period, therefore corrective action plans were not issued. Only the initial results were shared, and not the final re-survey results along with project close-out, which shows that surveyed providers who also failed the re-survey were eventually brought into compliance.

Compliance actions taken to ensure proper oversight:

- As of January 19, 2024, the Plan submitted its 2020 and 2021 After-Hours re-survey results as part of its response to address factual errors in the Behavioral Health Report (BHI) as shown in Attachments 1A.1 and 1A.2.
- As of February 1, 2024, the Plan is delegating behavioral health services to Magellan Health. Magellan Health submits a comprehensive system of monitoring adherence to access and availability standards to the Department including the following surveys, audits and reports. The Plan's protocols for oversight of Magellan Health's compliance include a thorough review of Magellan's policies and procedures, processes and reporting on an annual basis as well as necessary corrective action plans.
    - Telephone Response Statistics Reports, including After-Hours Telephone Response Statistics Reports, Average Speed of Answer and Call Abandonment Rate as part of the daily telephone reports from the Call Management System (CMS) and quarterly aggregated reports by local member and provider services staff
    - Customer Service Associate telephone audits
    - Member access complaints/grievances
    - Access to emergent/urgent appointment reports
    - Member satisfaction survey, including satisfaction with provider office wait times, availability of requested provider specialty and language availability
    - Provider satisfaction surveys
    - Provider access and availability surveys, including, but not limited to, routine, urgent, emergent access and office wait time
    - Geographic access and density reports

#3: Failure to ensure quality of care is being reviewed, problems identified, and effective action taken to improve care where deficiencies are identified.

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1) and (a)(3)

During the review period, the Plan's Customer Service team was aware that behavioral health provider access availability was limited. To further support enrollees, the Customer Service team provided

alternative in-network provider options and offered an out-of-network (OON) behavioral health provider process. Although the Customer Service representatives provided alternative resolutions, they did not routinely identify untimely appointment availability statements from enrollees as an enrollee complaint or grievance. System workflow and documentation processes did not provide an easy method for capturing these types of grievances, making it easier to miss the opportunity to identify and file a grievance for the member.

Results of the actions taken:

- System & Records
    - As of November 1, 2023, the Plan's new system workflow and documentation processes were put in place that facilitate Customer Service representatives to file grievances. The workflow prompts each Customer Service representative to attest to the need to file a standard or exempt grievance during each call. All call documentation has an internal decision tree. This system configuration determines whether the call will be documented as an inquiry, Type I grievance or standard grievance. It prompts the Customer Service representative to answer questions, starting with, "Has the enrollee expressed dissatisfaction?" If 'yes,' additional questions are prompted, resulting in filing as a Type I or Standard grievance case. All grievances are then available for review as part of the Plan's quality assurance program.
- Training (Classroom, Modules and Assessments)
    - New system workflow training for grievance cases was provided to the Customer Service team in September through October 2023 as shown in Attachments 3A – 3F. Additional Appeals and Grievances training will be provided to ensure agents can easily and readily identify a grievance opportunity during the enrollee interaction in April 2024. The focus will be placed on informing the enrollee of filing a grievance rather than not asking or offering to file a grievance.
- Oversight and Education
    - Daily, weekly and monthly leadership oversight are provided to the Customer Service team through 1:1 coaching, team meetings, and routine reporting review. Leaders review surveyed calls to identify opportunities for staff feedback. As of January 2024, leadership conducts internal routine audits to ensure exempt cases are filed accordingly. Quality call audit monitoring includes reviewing routine grievance case calls as shown in Attachment 3G.

#4: Failure to document follow-up when quality of care issues are identified. Additionally, the Plan is operating at variance with its filed Potential Quality of Care Issues policy.

Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(1) and 1300.70(b)(1)(A) and (B)

The Plan respectfully disagrees with the Department's finding that the Plan did not consistently follow up on Quality of Care (QOC) issues. As noted in the Plan's response to address factual errors in the BHI report on January 19, 2024, the Plan did not agree with the findings for Case #5 (P90042). The Plan has a formal process for review of follow-up on all cases at every Peer Review Committee (PRC) meeting, as detailed below.

- Case review of all follow-up cases at each PRC meeting, which was instituted after the 2021 Medical Survey.
- Requiring all answers to be sent in written format by due dates as part of the instituted formal process.

- The Plan chair of PRC provides education to reviewers and staff regarding the requirement to address all complaints through completion. Grievances are reviewed weekly during physician huddles.

Additional actions taken to enhance the process for review of quality of care issues:

- The Plan has implemented a formal process to ensure more detailed responses required to follow-up documentation of effectiveness. The Plan's Member Grievance policy has been updated on pages 10 – 11 and 23 as shown in Attachment 4A.
- As of November 15, 2023, the PRC Charter has been updated to include the process enhancements described above and approved by the PRC as shown in Attachment 4B.
- With Sharp HealthCare's (SHC) individual healthcare organizations, a new Peer Review Sharing agreement was implemented on December 1, 2022, which provides additional transparency within SHC's provider organizations and the Plan. This results in the ability to confirm action plans have been implemented across the organizations within SHC.
- Results include more consistent follow-up of quality issues allowing increased compliance with regulations.
- The Plan will continue to monitor and identify opportunities for improvement for QOC issues.

GRIEVANCES AND APPEALS
#5: Failure of customer service to identify all grievances.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Rules 1300.68(a)(1), (a)(2)

Please refer to the Plan's response to Findings #3.

#6: Failure to identify and log exempt grievances as required.

Statutory/Regulatory Reference(s): Section 1368(a)(4)(B)(i) and Rule 1300.68(d)(8)

Please refer to the Plan's response to Findings #3.

Additionally, the Plan's Customer Service team did not file exempt grievances when alternative options or resolutions were provided to enrollees. If an enrollee requested not to file a grievance as in File ID # 785656, 920525, 1227850 and 1398614, the Customer Service team did not consider the matter to warrant categorization as an exempt grievance. Regarding File ID #1227850, the enrollee did not want to file the grievance over the phone with the Plan's Customer Service team but instead requested to file an online grievance as shown on page 2 in Attachment 6A. As noted in File ID #1398614, the enrollee initially agreed to file a grievance but later decided not to proceed with filing as shown on page 1 in Attachment 6B. Additionally, the Plan determined that 2 cases were not filed due to the enrollee's request not to file a grievance, as referenced in Files ID #785656 as shown in Attachment 6C and File ID #920525 as shown in Attachment 6D. System and documentation processes did not provide an easy method of filing grievances, making it easier to miss the opportunity to identify and file a grievance for the member.

Results of the actions taken:

- Please refer to the Plan's response to Findings #3.