DEPARTMENT OF Managed Health Care

BEHAVIORAL HEALTH INVESTIGATIONS

Phase Three Summary Report

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) ensures health plan members have access to equitable, high-quality, timely and affordable health care within a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans under the Knox-Keene Health Care Service Plan Act of 1975. The Department regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets.

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

This Phase Three Summary BHI Report describes the findings of the following health plans:

- Aetna Health of California Inc.
- Chinese Community Health Plan dba Balance by CCHP
- Molina Healthcare of California
- San Francisco Health Authority dba San Francisco Health Plan
- UHC of California dba UnitedHealthcare of California

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

Key Knox-Keene Act Violation Findings:

- Five health plans each had three or more appointment availability and access violations, which could result in an enrollee's inability to obtain timely and geographically accessible appointments.
- Four health plans had at least one utilization management violation, resulting in failure to provide required training on clinical criteria, ensure consistent decision-making, and comply with post-stabilization requirements. These violations may lead to enrollees and/or providers receiving delayed notification of a health plan's

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

utilization management decision and inconsistent application of utilization management criteria.

- Five health plans each had three or more quality assurance violations. These violations may result in failure to identify and/or investigate quality of care issues, failure to provide competent customer service, lack of adequate delegate oversight, and provider credentialing process violations. These violations may result in enrollees receiving inconsistent or incorrect information, an inadequate network of providers, and untimely responses to enrollee grievances.
- Four health plans had at least one grievance and appeals violation, which could lead to enrollee grievances not being reviewed by the health plan, inconsistent application of policies and procedures and delays in notifying enrollees of their health care rights.
- One health plan had a claims payment violation.

Key Barrier Findings:

- Two health plans were unable to demonstrate they provide enrollees with sufficient messaging about how to access behavioral health services.
- Three health plans' processes for appointment referrals, case management or collaboration and coordination of care may negatively impact enrollees.
- One health plan lacks a process for tracking single case agreements.
- One health plan was found to have persistent gaps in its network adequacy for behavioral health services because of its reliance on non-participating providers.
- One health plan's prior authorization requirements are unclear.
- Four health plans or their behavioral health delegate(s) use a customer service system that does not track repeat callers.
- One health plan has a high customer service overturn rate, which may impede effective and efficient customer service.
- One health plan does not have a system to monitor enrollee calls made to its behavioral health delegate.
- One health plan does not have a process to track and monitor telephone calls to providers.
- One health plan does not have a process to track Independent Medical Review overturn data.
- Two health plans either lack a system or use an ineffective system for tracking, trending or reviewing grievances.
- Two health plans' provider reimbursement practices and auditing processes create barriers for providers.
- One health plan lacks processes to ensure delivery of culturally competent behavioral health care and fails to monitor and address disparities among the enrollee population.

- One health plan and its pharmacy benefit manager lack processes to assist enrollees with reminders for medication compliance.
- One health plan's credentialing and contracting process, and its online provider portal structure create barriers for providers.
- One health plan was unable to demonstrate it addressed poor provider satisfaction survey results.

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

INTRODUCTION AND BACKGROUND

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

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

Beginning July 1, 2022, health plans were required to ensure that their contracted provider networks are able to offer non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider within 10 business

days of the prior appointment, or longer if the treating provider determines a longer wait time will not have a detrimental impact on the health of the enrollee, as required by SB 221 (Wiener, 2021). SB 221 also requires health plans to arrange coverage outside of the health plan's contracted network if medically necessary treatment of a mental health or substance use disorder is not timely available with an in-network provider. The Department incorporated these requirements into the annual timely access filing and annual review of provider networks. In addition, the Department will monitor compliance through the routine medical survey process.[2]

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

The BHIs include assessment of the health plans' behavioral health delivery system, including the operations of any behavioral health and/or pharmacy benefit manager, with a focus on the enrollee experience.[3]

The full-service commercial health plans subject to the BHIs are investigated in phases. The Department selected the health plans for each phase based on enrollment size, counties of operation, and how the health plan provides behavioral health services to their enrollees, such as the use of a specialized behavioral health plan. In addition, the Department sought to avoid scheduling the investigations near or during a Department routine or follow-up medical survey.

METHODS

To evaluate health plan operations, the Department requested and reviewed documents, files and data of each health plan and the health plans' respective behavioral health delegate and/or pharmacy benefit managers. The Department also conducted interviews with the health plans and delegates.

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[2] The review periods for the health plans' BHIs were as follows: Balance by CCHP April 1, 2021 through March 31, 2023; Molina Healthcare of California April 1, 2021 through May 31, 2023; Aetna Health of California Inc. March 1, 2022 through February 29, 2024; San Francisco Health Plan April 1, 2022 through March 31, 2024; UnitedHeathcare of California June 1, 2022 through May 31, 2024.

[3] The BHIs do not include health plan products or health 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 separately interviewed enrollees and providers about their experiences with the health plans.

The BHIs focused on the following areas:

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

SUMMARY OF KNOX-KEENE ACT VIOLATIONS

The Department identified 39 separate Knox-Keene Act violations that, in some instances, applied to multiple health plans.

	Knox-Keene Act Violations	Health Plans
Appointment Availability and Timely Access		
1	The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards. Sections 1367.03(a)(1), 1367.03(a)(5); Rule 1300.67.2.2(c)(5)	• Balance by CCHP • San Francisco Health Plan
2	The Plan does not have a process (or fails to ensure its delegate has a process) to ensure enrollees who call the Plan or delegate to submit grievances about delays or difficulties obtaining behavioral health services are offered appointments that meet timely access standards. Sections 1367.03(a)(5), 1368(a)(1); Rules 1300.68(a)(4), 1300.67.2.2(b)	• Aetna Health of California Inc. • Balance by CCHP • Molina Healthcare of California • UnitedHealthcare of California
3	The Plan failed to ensure its behavioral health delegate offers enrollees behavioral health appointments within timeliness standards. Sections 1367.03(a)(5)(E), 1367.03(c); Rule 1300.67.2.2(c)(5)(E)	• San Francisco Health Plan
4	The Plan fails to (or fails to ensure its delegate) consistently identify, investigate and document potential provider directory inaccuracies reported to member services. Sections 1367.27(j)(3), 1367.27(o)(1) and 1367.27(o)(2)(B)	• Aetna Health of California Inc. • Balance by CCHP • Molina Healthcare of California • UnitedHealthcare of California
5	The Plan does not include autism service providers in its network, or monitor network adequacy, including timely and geographic accessibility, for Pervasive Developmental Disorder and autism services. Section 1374.73(b); Rule 1300.74.73(a)(3)(D) and Rule 1300.74.73(b)	• Balance by CCHP
6	Failure to consistently conduct an annual enrollee experience survey as required. Rule 1300.67.2.2(d)(2)(B)	• San Francisco Health Plan
7	The Plan fails to ensure its delegate consistently arranges for the timely provision of in-network and out-of-network behavioral health care services. Sections 1367(d), 1367.03(a)(1), and 1367.03 (a)(5)(A)-(F), and (7)(C), 1367.03(c), 1374.72(a)(1)	• Aetna Health of California Inc. • Molina Healthcare of California • UnitedHealthcare of California

	Knox-Keene Act Violations	Health Plans
	and (d), 1374.721(f)(3)(A) and Rule 1300.67.2.2(c)(1)	
8	The Plan failed to demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had agreed to an appropriate care plan. Section 1367.01(h)(3)	• Aetna Health of California Inc.
Utilization Management, including Triage and Screening		
9	The Plan was unable to demonstrate all persons who conduct utilization review, review claims, and/or make medical necessity determinations for behavioral health services received the required formal training on nonprofit association criteria. Section 1374.721(e)(1)	• Molina Healthcare of California • San Francisco Health Plan
10	The Plan did not demonstrate that all staff who conduct utilization review passed interrater reliability testing. Sections 1374.721(e)(5), 1374.721(f)(3)(A), and 1374.721(h)	• Molina Healthcare of California • San Francisco Health Plan
11	Plan is unable to demonstrate that its behavioral health utilization management staff consistently used the nonprofit professional association (NPA) criteria when required. Section 1374.721(b)	• Molina Healthcare of California
12	The Plan or its delegate does not have a process to continuously review utilization of behavioral health services and facilities.[4] Section 1367.01(j), Rules 1300.70(a)(1), (3) and 1300.70(c)	• Molina Healthcare of California • San Francisco Health Plan • UnitedHealthcare of California
13	The Plan does not include the correct information in its denial and modification letters to enrollees, including providing contact information for the wrong regulator. Sections 1367.01(h)(4), 1368(a)(1), 1368.02(b); Rules 1300.68(a), (b)(2)	• Aetna Health of California Inc.
14	The Plan's policies and procedures or delegate's process for post-stabilization services are inconsistent with Knox-Keene Act requirements. Sections 1371.4(a), (j)(1)-(3), 1262.8(b)(2)(B), 1262.8(d)(1)(A), 1262.8(d)(1)(B), 1262.8(d)(2),	• Molina Healthcare of California • UnitedHealthcare of California

[4] This violation was included under the area of Quality Assurance in the individual BHI report for Molina Healthcare of California, and under the area of Utilization Management, including Triage and Screening in the individual BHI reports for San Francisco Health Plan and Molina Healthcare of California. In this Summary Report, for purposes of consistency, the violation is included in the Utilization Management area.

	Knox-Keene Act Violations	Health Plans
	1262.8(i), 1262.8(j) and 1262.8(k), and Rules 1300.71.4(b), 1300.71.4(b)(2) and 1300.71.4(c).	
15	The Plan fails to consistently ensure appropriate discharge planning for enrollees. Sections 1367(d), 1367.03(a)(5)(F) and 1374.72(d)	• Molina Healthcare of California
16	The Plan could not demonstrate that medical necessity decisions for transcranial magnetic stimulation (TMS) treatment were consistent with criteria and guidelines that are supported by clinical principles and processes. Also, the Plan's denial and modification letters for TMS failed to include a clear explanation of the reasons for its decisions and the clinical reasons for the decisions regarding medical necessity. Sections 1374.721(a), 1374.721(b), 1374.721(c), 1374.721(f)(1) and 1374.721(f)(4), 1363.5(a), 1363.5(b)(2), 1363.5(b)(4) and 1363.5(b)(5), and 1367.01(h)(4)	• Molina Healthcare of California
	Quality Assurance	
17	Failure to have a Maternal Mental Health Program or failure of the Maternal Mental Health program to include quality measures to encourage screening, diagnosis, treatment and referral. Section 1367.265(a)	• Aetna Health of California Inc. • Balance by CCHP • San Francsico Health Plan
18	Plan or delegate customer service representatives are not consistently knowledgeable and competent in providing customer service. Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10)	• Aetna Health of California Inc. • Balance by CCHP • San Francisco Health Plan • UnitedHealthcare of California
19	The Plan does not have a process for monitoring and evaluating the effectiveness of behavioral health triage and screening services for both non-urgent and urgent services. Sections 1367.03(a)(8)(A) and 1367.03(e)(5)	• Balance by CCHP
20	The Plan does not conduct adequate oversight of its behavioral health delegate to ensure compliance with required utilization management program standards. Sections 1367.01(a) and 1367.01(j)	• San Francisco Health Plan
21	The Plan does not conduct adequate oversight to ensure the behavioral health delegate identified and referred all grievances to the Plan. Section 1370; Rules 1300.70(a)(3) and 1300.70(b)(1)(B)	• San Francisco Health Plan
22	The Plan does not adequately oversee its behavioral health triage and crisis line delegate.	• Molina Healthcare of California

	Knox-Keene Act Violations	Health Plans
	Sections 1367.03(a)(8) and 1367.03(e); Rules 1300.67.2.2(c)(8), 1300.67.2.2(b)(19), 1300.67.2.2(b)(20) and 1300.70(b)(2)(B)	
23	The Plan fails to monitor and take effective action to correct identified timely access issues. Section 1367.03(a)(1); Rules 1300.67.2.2(c)(1), 1300.70(a)(1), 1300.70(a)(3) and 1300.70(b)(1)(B)	• Molina Healthcare of California
24	The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.[5] Section 1374.197(a)	• Aetna Health of California Inc. • Balance by CCHP • Molina Healthcare of California • San Francsico Health Plan
25	The Plan fails to ensure that credentialing applications for behavioral health providers are confirmed, assessed, and verified as required Section 1374.197(a)	• Molina Healthcare of California
26	The Plan was operating at variance with its filed provider directory policies and procedures. Section 1386(b)(1)	• Aetna Health of California Inc. • Balance by CCHP
27	The Plan was operating at variance with its filed Provider Appointment Access Standards policy. Section 1386(b)(1)	• Balance by CCHP
28	The Plan was operating at variance with its filed quality assurance policy and procedure. Section 1386(b)(1)	• San Francisco Health Plan
29	The Plan was operating at variance with its filed utilization management policy and procedure. Section 1386(b)(1)	• Aetna Health of California Inc. • San Francisco Health Plan
30	The Plan was operating at variance with its SB 855 compliance filing.[6] Section 1386(b)(1)	• Molina Healthcare of California • San Francisco Health Plan
31	The Plan was operating at variance with its filed Delegation Agreement. Section 1386(b)(1)	• San Francisco Health Plan • UnitedHealthcare of California
32	The Plan was operating at variance with its filed access policies and procedures. Section 1386(b)(1)	• San Francisco Health Plan

[5] This violation was included under the area of Utilization Management, including Triage and Screening in the individual BHI reports for Balance by CCHP, San Francisco Health Plan, and under the area of Quality Assurance in the individual BHI reports for Aetna Health of California Inc. and Molina Healthcare of California. In this Summary Report and all future BHI Reports, the violation will be included in the Quality Assurance area.

[6] This violation was included under the area of Grievance and Appeals in the individual BHI report for Molina Healthcare of California, and under the area of Quality Assurance in the individual BHI report for San Francisco Health Plan. In this Summary Report and all future BHI Reports, the violation will be included in the Quality Assurance area.

	Knox-Keene Act Violations	Health Plans
33	The Plan is operating at variance with its filed complaints, grievances and appeals policies and procedures. Section 1386(b)(1)	• Aetna Health of California Inc.
34	The Plan failed to file its delegation oversight policy and procedure with the Department. Sections 1351(m) and 1352(a); Rule 1300.52.4(b)(i)(A)	• UnitedHealthcare of California
	Grievances and Appeals	
35	The Plan does not consistently identify oral expressions of dissatisfaction as grievances. Section 1368(a)(1); Rule 1300.68(a)(1)	• Aetna Health of California Inc. • Balance by CCHP • Molina Healthcare of California • UnitedHealthcare of California
36	The Plan failed to demonstrate it maintains and periodically reviews the required log of exempt grievances. Section 1368(a)(4)(B)(i); Rules 1300.68(b)(1) and 1300.68(d)(8)	• Aetna Health of California Inc.
37	The Plan fails to ensure its delegate consistently and adequately considers all issues within enrollee grievances and provide rectification when appropriate. Section 1368(a)(1); Rule 1300.68(a)(4)	• UnitedHealthcare of California
38	The Plan's website does not include information about accessing behavioral health care services and other Knox-Keene Act required information and fails to include a link to its behavioral health delegate's website. Sections 1368.015(f)(1), 1368.015(f)(2) and 1368.016(a), (h).	• UnitedHealthcare of California
	Claims Submission and Payment	
39	The Plan permitted its behavioral health delegate to engage in unjust payment patterns. Rules 1300.71(a)(8) and 1300.71(b)(1)	• San Francisco Health Plan

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

The Department identified 22 barriers to care among the five health plans reviewed in this phase. Several of the barriers apply to multiple health plans. Each barrier is described in detail below.

Appointment Availability and Timely Access

1. **The Plan does not provide enrollees with sufficient messaging about how to access behavioral health services, and enrollees experience difficulties when trying to obtain behavioral health services.**

   Impacted Health Plans: Balance by CCHP, Molina Healthcare of California

To access timely behavioral health services, enrollees need to have a basic understanding of how to seek, request and obtain services from their health plan or delegate. Health plans and/or their behavioral health delegates should therefore provide enrollees with direct, clear messaging on how to obtain services from behavioral health providers, whether prior authorization or a referral is required, what steps to take and what phone number(s) to call for assistance.

Balance by CCHP stated enrollees are provided information about how to access behavioral health services via the Plan's Evidence of Coverage (EOC) and the Plan's website. Although the Plan's EOC states enrollees must obtain a referral from their primary care physician to see a specialist, it may not be clear to all enrollees that therapists, psychologists, Applied Behavior Analysis (ABA) providers, substance use disorder counselors, residential services and other behavioral health providers are "specialists" requiring a referral. Additionally, behavioral health coverage information and the specialist referral process descriptions were located in different sections of the EOC, making it more difficult for enrollees to understand the process without searching different sections of the EOC. The Plan's website has a "Find a Doctor" button on the homepage, but it requires several steps to locate a particular type of behavioral health provider. The enrollee must also have an understanding of their health plan type and the applicable medical group to conduct an accurate provider search, and the medical group providing behavioral health services may be different from the medical group providing medical/surgical services.

Finally, review of Inquiry Files indicated some enrollees seeking behavioral health services experienced confusion and at times received misinformation from customer service representatives about how to access behavioral health services. In sum, the Plan's messaging on how to obtain behavioral health services is not clear and direct, and information from customer service representatives is not always accurate, creating a barrier to enrollees seeking behavioral health services.

Molina Healthcare of California's member ID cards do not identify what phone number enrollees should call to access behavioral health triage and screening services, or the behavioral health crisis line. Further, the Plan's website neither identifies how to access its behavioral health crisis telephone line nor includes a behavioral health-specific telephone line. Additionally, the EOC describes how enrollees may access medical services but does not discuss how to access behavioral health services and does not state in plain language whether prior authorization is required or self-referral is allowed. The Plan acknowledged that it did not conduct any outreach to its enrollees, such as sending out letters and/or emails educating enrollees about their behavioral health benefits, during the review period.

Recommendations and Other Considerations

The Department recommends Balance by CCHP review and revise information provided to enrollees to ensure messaging is clear, direct and easy to locate, both in written documentation, such as EOC documents, as well as on the Plan's website. The Plan should also provide additional training for their customer service representatives to improve communication with enrollees and ensure accurate information is disseminated.

Molina Healthcare of California should update the EOC documents to include specific steps for obtaining routine, urgent, and emergent behavioral health care. The Plan is also encouraged to update the Member ID cards and Plan website to include the Plan's behavioral health crisis telephone line and develop a behavioral health-specific telephone line. Last, the Plan is encouraged to send annual communications to enrollees, including but not limited to communications educating them about their behavioral health benefits.

2. **The Plan's requirement for enrollees to obtain a referral from their primary care physician (PCP) for behavioral health services may delay or present a barrier to timely access to services.**

Impacted Health Plans: Balance by CCHP

Unnecessary requirements or processes can serve as a barrier, delaying enrollees' ability to obtain timely behavioral health care services. Balance by CCHP requires enrollees to obtain a referral from their PCP in order to receive behavioral health services that do not require prior authorization, such as therapy and psychiatry services. The Plan stated the purpose of the referral is to have "control over the services," including, for example, alerting the utilization management department if an enrollee needs case management. However, the Plan's utilization management nurse was not aware of where PCP referrals were documented in the Plan's system, and was not aware of how referrals were monitored or tracked. No evidence was offered to explain how the Plan reviewed, documented, tracked or monitored PCP referrals for behavioral health services. The Plan was unable to provide any operational, clinical or other justification for requiring referrals for behavioral health services that are not subject to prior authorization. Enrollees who could otherwise directly schedule and obtain behavioral health services, are instructed by customer services representatives (CSRs) to go to their PCP for a referral. Enrollees who are uncomfortable contacting their PCP for a referral may not follow up, which could result in delays or the enrollee not receiving needed behavioral health care services.

Recommendations and Other Considerations

The Plan should consider removing requirements, such as PCP referrals, that may delay enrollees' ability to obtain timely behavioral health services. The Plan should consider whether its objectives in requiring PCP referrals, including case management needs, and other goals, could be achieved using methods that do not hinder enrollees from directly accessing behavioral health services. The Plan might also review and update any employee training and procedures consistent with these goals.

3. **The Plan has not demonstrated an effective process for collaboration and coordination of care between medical and behavioral health providers.**

Impacted Health Plans: Aetna Health of California Inc.

Collaboration and coordination of care involve communication and information sharing between primary care and behavioral health providers. Coordination of care can enhance patient quality of care and could improve enrollee outcomes.

Aetna Health of California Inc. has a process for monitoring continuity and coordination of care and collecting related data across the health care network. This process is intended to identify opportunities to improve coordination of medical care, coordination of behavioral health care and coordination between behavioral health and medical care through data collection and analyses. However, during the review period, data generally reflected decreased rates of practitioner-to-practitioner communication, and the Plan had not demonstrated improvement in this area which could impact patient care.

Recommendations and Other Considerations

The Plan should educate its provider network regarding record keeping practices and documentation of communication with other providers, including behavioral health providers. The Department also encourages the Plan to educate providers regarding reimbursement for these communications. Additionally, the Plan should add questions to templated forms prompting providers to consider whether information should be shared with other treating providers and chart audit forms to include verification regarding whether information was shared with another treating provider. The Plan should also educate enrollees on the importance of a treatment team, inform enrollees that they can request providers communicate with one another, and have enrollees sign release forms to facilitate holistic care.

4. **Behavioral health services, including specialty care, are not readily available at reasonable times to all enrollees throughout the Plan's service area.**

Impacted Health Plans: Aetna Health of California Inc.

Timely and accessible care is essential for promoting early detection and treatment of behavioral health conditions. Accessible behavioral healthcare also promotes health equity especially in underserved populations. Delays in accessing behavioral health services may lead to worse health outcomes and higher costs.

Aetna Health of California Inc.'s behavioral health access reports and case files revealed persistent gaps in network adequacy for behavioral health services, including specialty care, in certain geographic areas. These deficiencies, addressed through reliance on non-participating providers, indicate that behavioral health services are not consistently readily available at reasonable times to all enrollees throughout the Plan's service area.

Recommendations and Other Considerations

The Plan should identify areas of need and recruit and contract with providers in these practice and geographical areas. The Plan could offer competitive reimbursement rates and incentives for providers to join the Plan's network.

5. **The Plan's case management program does not actively assist enrollees in accessing behavioral health services.**

Impacted Health Plans: Molina Healthcare of California

Health plans are obligated to provide enrollees with timely access to behavioral health services, coordinate care and provide referrals when necessary. Health plans may assign case managers or care advocates to assist enrollees with complex needs in identifying appropriate providers and coordinating necessary care. However, when case managers do not provide effective assistance or are not proactive, enrollees needing high level behavioral health treatment and intervention may experience barriers.

Molina Healthcare of California's case management policy states the Plan offers case management to enrollees who "require extensive use of resources and would benefit from well-coordinated care" and the Plan "proactively identifies members who need Case Management using a variety of clinical care processes and data sources." The Department's review of the Plan's enrollee files demonstrated that case management did not contact enrollees when they transitioned from one level of care to another or experienced a significant medical or life event. The files failed to show consistent or active participation and interventions by the case managers and instead demonstrated case managers tracked the activities of the enrollees but did not become actively involved in assisting in or coordinating care.

Recommendations and Other Considerations

The Plan should implement a process to integrate behavioral health information into case management protocols, including establishing a protocol for referring enrollees who are experiencing a behavioral health crisis to case management, and training Case Managers in behavioral health services navigation. The Plan is also encouraged to monitor behavioral health engagement outcomes by tracking metrics such as referral completion rates, service utilization, and enrollee satisfaction to evaluate the effectiveness of case management support in behavioral health access.

6. **The Plan does not track all single case agreement (SCA) requests to identify potential gaps in network coverage.**

Impacted Health Plans: UnitedHealthcare of California

Health plans must execute SCAs with out-of-network providers when in-network providers are not available within geographic and timely access standards or for other various reasons, such as a shortage of providers in a certain area, no qualified specialists available, continuity of care, etc. If a health plan receives a high volume of SCA requests from out-of-network providers and/or enrollees, it may be an indication that the health plan has gaps in its network, providers do not want to contract with the

health plan, or enrollees may not be able to access care timely or any combination thereof.

The Plan's behavioral health delegate, U.S. Behavioral Health Plan, California (USBHP) acknowledged during interviews that it does not track the SCAs it receives. USBHP reports showed it received approximately 395 SCA requests during the BHI review period. Of those, 190 (48%) were offered by USBHP, but were never signed and/or returned by the provider. USBHP was unable to explain why it received so many SCA requests, or why out-of-network providers did not sign and return the SCAs. As a result of not having a process to track SCA requests, the Plan and USBHP may be missing opportunities to identify gaps in its network that cause a barrier to timely access to care for the Plan's enrollees. As an example, 141 (35%) of the SCA requests were for inpatient and/or residential treatment facilities, indicating the Plan and USBHP may have a gap of inpatient and residential based treatment facilities. Identifying the reasons for potential gaps in its network could assist the Plan in understanding why providers are not contracting and what USBHP could do differently to bring more providers in-network.

Recommendations and Other Considerations

The Plan and USBHP should implement a system to track all SCA requests, not just those SCA requests that are approved, to identify areas of potential network inadequacy. The Plan and USBHP should increase efforts to add these out-of-network providers, who are issued SCAs, into the network.

Utilization Management, including Triage and Screening

7. **The Plan's lack of clarity as to which behavioral health services require prior authorizations can cause enrollee and provider confusion.**

Impacted Health Plans: Molina Healthcare of California

Health plans should be transparent and communicate to enrollees in clear and plain language what behavioral health services an enrollee can self-refer to and what services require prior authorization. Without clear EOC language or communications to enrollees regarding behavioral health services that are or are not subject to prior authorization, an enrollee may not know when they can "self-refer" potentially resulting in delays, denials or other issues accessing services.

Molina Healthcare of California has multiple documents that provide information to providers about which services require prior authorization, but nothing specific for enrollees. The Plan created a list of behavioral health services that require prior authorization for the Department during the BHI, but this list is not available to enrollees. The Plan's EOCs direct enrollees to the Plan's website at www.molinamarketplace.com for a complete list of covered services that require prior authorization. The Department's investigators visited the Plan's general website identified in the EOC and found it extremely difficult to find a complete list of behavioral health services that require prior authorization. Given the Department's challenges in deciphering which behavioral health services require prior authorization, it is unreasonable for the Plan to expect

enrollees to fare any better when navigating Plan resources in order to obtain timely and appropriate care.

Recommendations and Other Considerations

The Plan should consider developing a comprehensive list of behavioral health services which details behavioral health treatments, procedures, and medications that require prior authorization. This list should be updated regularly to reflect current clinical guidelines and utilization management policies. Enrollees would also benefit if the Plan incorporated clear and plain language regarding prior authorization guidance into EOCs and care coordination communications to ensure enrollees understand which behavioral health services may require prior approval.

Quality Assurance

8. **The Plan does not have a system to track and/or address customer service calls for repeat callers to identify trends, patterns or problems.**

   Impacted Health Plans: Aetna Health of California Inc., Balance by CCHP, Molina Healthcare of California, and UnitedHealthcare of California

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

Balance by CCHP has a policy requiring Plan departments to follow up on an enrollee inquiry when referred by the member services department, but otherwise did not have a process during the Plan's BHI review period to track the frequency or dates of contact by enrollees making repeated attempts to make behavioral health appointments. The Director of Customer Service stated that the Plan recently initiated a tracking process.

During interviews with Aetna Health of California Inc., the Plan was asked how the customer service team was trained to deal with enrollees who stated they had called previously for the same issue. The Plan stated the process was to solve the issue or initiate a request where the Plan offers to help the enrollee find an available provider if the issue was related to obtaining an appointment. However, the Plan did not have any documentation to demonstrate it tracks repeat callers.

The Department asked Molina Healthcare of California how it manages repeat callers and the Plan responded that the incidence of repeat callers with behavioral health issues is "very small." The Plan provided a sample repeat caller report, which identified seven repeat callers over a 60-day period. The Department's review of the Plan's sample repeat caller report found six of the seven (86%) callers had called more than once to obtain assistance in finding a behavioral health provider.

During interviews, UnitedHealthcare of California and its behavioral health delegate USBHP were asked if repeat caller data was reviewed to track issues or identify enrollees whose issues were not resolved by the CSRs. USBHP's Regional Manager of Behavioral Health Member and Provider Services stated USBHP listens to repeat calls

and escalated calls but did not describe any process or actions USBHP takes in response to listening to such calls, such as identifying trends in repeat calls or assessing access issues.

By not having a system to accurately track and trend repeat callers, health plans are unable to monitor instances in which callers are not getting the assistance they require and therefore the health plan cannot fully evaluate the effectiveness of customer service operations. Moreover, enrollees who call repeatedly and fail to get the assistance they need may be unable to obtain timely, appropriate health care services.

Recommendations and Other Considerations

Health plans should develop and implement a system to document and track repeat callers and related data, and compile and periodically review reports of such data. This type of system would improve health plans' ability to identify potential network adequacy trends, develop methods to increase the effectiveness of customer service operations, and enhance enrollees' ability to obtain appropriate, timely behavioral health services.

9. **The Plan does not have a mechanism to monitor enrollee telephone calls made to the behavioral health delegate.**

Impacted Health Plans: San Francisco Health Plan

Enrollees who call a behavioral health delegate regarding behavioral health services may also take the opportunity to raise other concerns. For example, an enrollee may express difficulty finding a behavioral health provider, inability to get a timely appointment, problems with providers or the delegate, billing issues or other concerns requiring health plan or delegate follow-up.

San Francisco Health Plan delegates behavioral health services to San Francisco Behavioral Health Services (BHS). Although BHS reports grievances to the Plan, there is no Plan oversight to ensure BHS captures all grievances made by enrollees during telephone calls. BHS does not record incoming enrollee telephone calls and there is no monitoring by the Plan or reporting of calls identified by the delegate as inquiry calls. By not monitoring enrollee telephone calls to BHS, the Plan cannot be certain it is informed of all enrollee grievances, identifies, tracks and trends enrollee difficulties obtaining behavioral health services, or addresses and tracks issues requiring additional follow-up.

Recommendations and Other Considerations

The Plan should develop and implement a process to ensure its behavioral health delegate accurately and timely reports all grievances to the Plan. Such a system may include monitoring enrollee calls made to the delegate, a system of reporting by the delegate, or other tracking system subject to Plan review and oversight.

Additionally, the Plan should work with BHS to implement specific training and job aids to be used by delegate customer service staff to ensure enrollee communications are thoroughly documented.

10. **The Plan does not have a process to track and monitor telephone calls from providers.**

Impacted Health Plans: San Francisco Health Plan

Tracking and monitoring issues reported by providers to health plans allow the health plan to identify trends, both positive and negative, impacting enrollees, services, health plan-provider relationships and a host of other issues. By tracking and monitoring these issues, health plans can strategize and implement processes to improve their operations.

San Francisco Health Plan stated provider calls about enrollees are documented in the enrollee's record, and the Plan receives an annual report from its behavioral health delegate, BHS, concerning claims payment and provider dispute resolution. However, the Plan did not have a mechanism for ongoing, consistent monitoring of provider calls pertaining to anything other than claims. The Plan did not have a formal tracking system in place for provider telephone queries or a mechanism for receiving, documenting, analyzing or addressing broader issues or concerns submitted by behavioral health providers. This lack of standardized tracking hinders the Plan's ability to identify trends and address systemic issues involving the delegate's contracted providers.

Recommendations and Other Considerations

The Plan should develop and implement a system allowing the Plan to monitor, document and track provider calls and issues raised by providers to ensure systemic issues are identified and addressed.

11. **The Plan's high customer service staff turnover rate impedes efficient and effective customer service**.

Impacted Health Plans: San Francisco Health Plan

Calling a health plan's customer service department is often an enrollee's first step in trying to obtain behavioral health services. Even when a health plan has a behavioral health delegate, the enrollee may first call the health plan. It is therefore important that health plan CSRs are trained and have an understanding of enrollees' behavioral health benefits.

San Francisco Health Plan delegates behavioral health services to BHS, but the Plan also receives calls from enrollees. During the Plan's BHI review period, the Plan reported an 84% turnover rate within the Plan's customer service department, including CSRs and other staff. With such a high turnover rate, the customer service department must continually onboard and train new staff. Because new staff lack institutional knowledge and Plan experience, they are less likely to provide efficient customer service and accurate information to enrollees. Additionally, review of Plan inquiry case files demonstrated instances of inaccurate information provided by CSRs to enrollees. Because the information about behavioral health services was not always accurate, enrollees may have experienced delays in obtaining care.

Recommendations and Other Considerations

The Plan should analyze, identify and address shortcomings in the knowledge, skill efficacy and job satisfaction of Plan customer service staff. Effective analysis may include obtaining feedback from current staff regarding training, workload, and barriers to staff retention. The Plan should develop strategies to address the root cause(s) of the high overturn rate.

12. **Neither the Plan nor USBHP review Independent Medical Review (IMR) overturn data to track whether denials are creating unnecessary barriers for access to behavioral health care.**

Impacted Health Plans: UnitedHealthcare of California

Health plan approvals of medically necessary behavioral health services are crucial for enrollee access to care. When a health plan denies or modifies a service based in whole or in part on a determination that the requested service is not medically necessary, the enrollee may file a grievance with the health plan to appeal the health plan's denial or modification. However, if the health plan upholds its denial or modification through the grievance process, the denial is eligible to be reviewed through the Department's IMR process. This process to obtain a medically necessary service may take months and may discourage enrollees from going through the appeals process. If most of a health plan's denials are being overturned through the Department's IMR process, it may indicate that the health plan is inappropriately denying medically necessary behavioral health services and creating barriers to care for its enrollees.

The Department found that denials of behavioral health services made by the Plan's behavioral health delegate, USBHP, during the review period were overturned by the IMR process 76%[7] of the time, meaning the IMR physician or panel found those requested services were medically necessary and overturned USBHP's denial. If a high percentage of enrollee complaints submitted to IMR are being overturned by the Department's IMR process, that may indicate USBHP may be inappropriately denying medically necessary behavioral health services and causing unnecessary barriers to behavioral health care. This barrier may cause, among other issues, delays in enrollee access to medically necessary care by having to file appeals, not receiving medically necessary care at all, or dissuade providers from recommending services that USBHP may deny.

Recommendations and Other Considerations

The Plan and USBHP are encouraged to implement a system to track and analyze high IMR overturn data, evaluate whether correct clinical criteria were applied in making the initial determination, assess whether other reasons contribute to high overturn rates, and take steps to address underlying causes. Tracking and addressing reasons for high

[7] The Plan's IMR information indicated there were 13 requests for IMR during the BHI review period. Of the 13 requests, 12 were submitted by the Plan for IMR, nine of which were overturned by the IMR physician or panel. The one other request was not submitted by the Plan for IMR because the Plan reversed USBHP's denial. In sum, of the 13 requests for IMR, 10 denials were overturned or reversed and three were upheld.

IMR overturn rates may result in more accurate initial authorization determinations and a reduction in the denial rate of certain services. Additionally, this information should be used to educate and train Plan and delegate utilization management staff on relevant issues.

Grievances and Appeals

13. **The Plan does not have a system to adequately track, monitor and review grievances in order to improve the delivery of behavioral health services.**

Impacted Health Plan: Aetna Health of California Inc.

A health plan system that has the ability to track, monitor and review behavioral health grievances permits the health plan to identify issues ranging from appointment availability to quality of care. Additionally, behavioral health grievance data can provide a health plan with information about how well the health plan is meeting enrollee needs.

In response to a request for documents demonstrating how Aetna Health of California Inc. tracks and monitors behavioral health grievances, the Plan provided board of director reports. However, those reports do not break out the grievances and appeals by behavioral health issues. The Plan failed to provide any documentation showing that it tracks and monitors behavioral health grievances. As a result of not having a process for tracking and trending quality of service grievances related to behavioral health, the Plan is not able to identify quality of service issues and is unable to improve the delivery of behavioral health services.

Recommendations and Other Considerations

The Plan should develop a process for tracking and trending grievances related to behavioral health. By tracking and trending this data, the Plan will be able to identify trends, recurrent enrollee and provider issues and improve the delivery of behavioral health services.

14. **The Plan is unable to accurately track and trend access and availability related enrollee grievances because the Plan uses multiple subcategories to track behavioral health grievances.**

Impacted Health Plan: Molina Healthcare of California

A health plan that tracks grievances using limited, appropriate categories can help the health plan identify systemic issues within the relevant categories and make necessary changes. The categories should be specific to issues, such as access and availability of behavioral health providers, yet broad enough that health plans can meaningfully identify systemic issues.

The Plan's Grievance and Appeal Log demonstrated that 83 out of 101 (81%) of grievances were assigned a primary grievance category of "Access and Availability." However, the Plan's approach of further delineation of grievance subcategories includes the use of multiple combinations of unique categories, which hinders accurate trending

of access and availability behavioral health grievances due to the unnecessarily expansive range of access related grievance issues faced by the Plan's enrollees.

As an example, the Plan has a behavioral health grievance category labeled as: "Access and Availability, Behavioral Health, Unable to Locate, Psychiatrist," which includes grievances where enrollees were unable to find an in-network psychiatrist. The Plan also has another category labeled: "Access and Availability, Behavioral Health, Appointment Availability, Psychiatrist," which includes grievances involving enrollees unable to make an appointment with an in-network psychiatrist. Both grievance categories capture the same overriding issue: enrollee access to in-network psychiatrists. The Plan's resolution for grievances in both categories is the same: the enrollee is assigned a Case Manager for assistance in accessing an in-network psychiatrist. However, because these two similar grievances are placed into different subcategories, it does not appear to the Plan that there is a trending issue with access to psychiatrists.

During interviews, when asked if the Plan identified any trends in behavioral health grievance issues, Plan staff stated they had not and reported that all the 15 unique categories were "a one off." However, when the Department reviewed the issues raised within the grievances, it found a majority represented two specific trends. In 44 of the 101 (44%) cases, enrollees were having difficulty obtaining a psychiatrist appointment. This issue was categorized with three different combinations of subcategories. In 29 of 101 (29%) cases, the enrollee was having difficulty obtaining a therapy visit. This issue was categorized with six different combinations of subcategories.

The Plan's use of superfluous subcategories results in a missed opportunity to identify, track, trend and remedy access issues that are negatively impacting enrollees' ability to obtain timely behavioral health appointments.

Recommendations and Other Considerations

The Plan should consider developing a streamlined process for naming, tracking and trending appropriate behavioral health grievances categories. Categories broad enough to capture systemic issues, yet specific enough to allow the Plan to identify the issue, along with a process to review and analyze the data, could improve the Plan's grievance and appeals operations. By tracking and trending this data, the Plan will have an opportunity to identify and address significant issues and improve the delivery of behavioral health services.

Pharmacy/Prescription Drug Services

15. **Neither the Plan nor its Pharmacy Benefit Manager has a process to assist enrollees with reminders for medication compliance.**

Impacted Health Plans: Balance by CCHP

Enrollees with high-risk behavioral health conditions can suffer potentially serious and dangerous outcomes if they become noncompliant with medication requirements. Barriers or difficulties in obtaining prescribed medications may cause an enrollee to interrupt or discontinue important medication. Missed doses or discontinued

medications may exacerbate symptoms and result in damaging behavior, either to self or to others. It is therefore critical for high-risk enrollees to remain consistent with medication requirements.

Pharmacy Benefit Manager refill protocols often include a process for denying medication refills when a refill is requested prior to the expected refill date. For safety reasons, only specific amounts or quantities of medication may be dispensed within a certain period of time. These quantity limits vary for different medications. Timely reminders sent to enrollees when it is time to refill medication could prevent missed medication or noncompliance. Balance by CCHP and its Pharmacy Benefit Manager were not aware of having a process in place for the Plan or Pharmacy Benefit Manager to provide reminder assistance for enrollees with a behavioral health condition.

Recommendations and Other Considerations

The Plan should consider the feasibility of working with its Pharmacy Benefit Manager to develop a process for sending enrollees timely reminders when it is time to refill medication which could prevent missed medications or noncompliance. Additionally, the Plan could develop a process to provide notifications and education to encourage enrollees to remain compliant with medications. Finally, the Plan should consider whether auto refills and auto prior authorization might be helpful for enrollees with serious mental illness (SMI) or serious emotional disturbance (SED), as defined in the DSM, especially for anti-psychotic medications.

Claims Submission and Payment

16. **Plan reimbursement practices create a barrier to increasing the number of in-network behavioral health care providers sufficient to meet the needs of enrollees.**

Impacted Health Plan: Aetna Health of California Inc. and UnitedHealthcare of California

Accurate, equitable and efficient reimbursement practices by health plans are essential to ensuring providers can consistently deliver timely, appropriate high-quality behavioral health care services. Reimbursement directly impacts a provider's financial stability and the quality of patient care. For providers, strong reimbursement practices lead to timely and accurate payments and allow providers to administer care without financial obstacles. When providers are financially stable, they are more likely to contract with the health plan, which increases the choices available to enrollees to ensure they have access to necessary care. In addition, competitive payment rates by a health plan allow the health plans to attract a wider network of providers and increase access to behavioral health care services.

Aetna Health of California Inc.'s payment rates are considered low by providers and the Plan's reimbursement practices create barriers for providers, thus impeding the ability to improve access by increasing the number of network providers. In a Quality Management Report provided by the Plan, the number one category of complaints by providers for all quarters in 2023 was related to the use of incorrect contractor or negotiated rate. For the first three quarters of 2023, the number three category of

complaints was incorrect non-participating fee schedule. Interviews with providers and file review revealed providers' difficulties obtaining provider fee-rate increases and lack of communication from the Plan regarding the ability to negotiate fee rates. The lack of accurate, equitable and efficient reimbursement practices can impact provider satisfaction and ultimately, the quality of care.

With respect to UnitedHealthcare of California and its delegate USBHP's payment rates, USBHP's 2023 Behavioral Health Provider Survey Results – California, showed a 3% increase in provider satisfaction with reimbursement from 2022 to 2023 (increasing from 46% to 49%). Despite the modest increase, a 49% satisfaction rate demonstrates a majority of the in-network behavioral health providers are not satisfied with the reimbursement rates. USBHP's Quality Improvement and Utilization Management Programs 2023 Evaluation included results from a "Clinician Satisfaction Survey," which identified "Lack of provider satisfaction with reimbursement rates," as a barrier. The proposed interventions included "Negotiated changes to provider reimbursement (07/14/23)," without any additional detail. USBHP's reimbursement rates are perceived as low by providers which could pose barriers to providers joining USBHP's network and, therefore, a barrier to the Plan's enrollees accessing in-network behavioral health care providers.

Recommendations and Other Considerations

The health plans should develop strategies for assessing and addressing contracted provider complaints regarding reimbursement, and review factors such as rate comparability, reimbursement accuracy, provider communication and how the health plan may be perceived by prospective providers considering contracting with the Plan.

17. **The Plan's electronic claim submission system is not adequately maintained to prevent improper denials, which creates a barrier to timely reimbursement.**

Impacted Health Plan: Aetna Health of California Inc.

Automatic denials of claims for behavioral health services that do not require prior authorization or referral, can lead to negative consequences including delayed reimbursement for providers and disrupted care for enrollees. Enrollees may experience treatment delays and providers may encounter additional administrative burdens from having to resubmit claims or file appeals for claims which were improperly denied due to auto-adjudication.

In reviewing provider appeals related to claim payments, the Department found that Aetna Health of California Inc. denied claims on grounds that a referral was required. During interviews, when questioned as to why the claims were denied when no referral was required, the Plan advised that these claims were incorrectly auto-adjudicated by the Plan's claims system. The Plan's claims system was subsequently updated to allow these types of behavioral health claims to be auto-adjudicated without referral. However, the claims identified by the Department were adjudicated in a two-year time period before correction and issues were not identified until a provider appeal was initiated. It is unclear how many additional claims were improperly auto-adjudicated during this period without correction by the Plan.

Recommendations and Other Considerations

The Plan should conduct a root cause analysis and repair of the incorrect auto-adjudication to prevent future issues. The Plan should also conduct regular audits of its claims payment system to review claims denied because of auto-adjudication and reprocess any claims that were improperly denied.

18. **Pre-payment and post-payment audits by the USBHP's Payment Network Integrity (PNI) unit may discourage providers from accepting Plan enrollees.**

Impacted Health Plan: UnitedHealthcare of California

Department interviews with providers indicate UnitedHealthcare of California's behavioral health delegate, USBHP's, process for requesting reimbursement for overpayment of claims may present a barrier by discouraging providers from accepting Plan enrollees. Providers described receiving letters they perceived as "threatening," from USBHP's PNI unit requesting reimbursement for payments already received by the providers, a practice called post-payment review. Providers asserted they billed appropriately for services rendered and the PNI letters were unwarranted. Further, to avoid receiving these types of letters, some providers resorted to billing a lower-level code for a behavioral health service or procedure than that for the service provided, resulting in lower reimbursements. Providers also stated USBHP's PNI letters prompted colleagues to down-code to avoid the pre- and post-payment audits and receiving the perceived threatening letters.

The execution of USBHP's pre- and post-payment review audits pose a potential barrier to in-network providers who may subsequently opt to not contract with USBHP or, as providers reported, accept less reimbursement than due for the behavioral health services provided to the Plan's enrollees. This practice could also be a barrier to enrollees as providers may not accept enrollees of the Plan to avoid USBHP's aggressive pre- and post-payment audit practices.

Recommendations and Other Considerations

The Plan and USBHP should review and evaluate their pre- and post-payment review and audit practices. Additionally, the Plan and its delegate should consider revising letter content that could be perceived as threatening or harsh. Finally, reimbursement practices and provider communications that are accurate, transparent and respectful can lead to improved Plan/Delegate-provider relations. Should providers require education regarding proper billing practices, appropriate education should be provided.

Cultural Competency, Health Equity and Language Assistance

19. **The Plan lacks processes for ensuring delivery of culturally competent behavioral health care as well as monitoring and addressing disparities among the enrollee population.**

Impacted Health Plans: Balance by CCHP

Studies suggest that lack of cultural competency in the health care setting can result in adverse patient safety events. Health care services rendered without consideration of cultural and linguistic needs and circumstances may result in diagnostic errors, unexpected negative responses to medication, harmful treatment interactions from simultaneous use of traditional medicines, inappropriate care transitions, and inadequate patient adherence to provider recommendations and follow-up visits. Additionally, there are indications showing racial minorities are less likely to have adequate access, seek help and have their mental health disorders diagnosed. LGBTQ populations experience higher rates of mental disorders such as anxiety and depression, have higher rates of suicidal ideation and are subject to more emotional, physical and sexual trauma than straight and cisgender people.

Balance by CCHP was unable to provide documents to demonstrate the Plan has a process to address cultural competency related to the delivery of behavioral health services, that cultural competency training is provided to providers and Plan staff, that it oversees and monitors contracted providers to ensure they meet enrollee cultural needs and preferences, that it conducts community outreach to engage with racial, cultural, linguistic and other communities, or that it has a process to identify disparities and develop strategies for addressing disparities across its enrollee population related to accessing behavioral health services, including disparities related to age, sex, race, culture, religion, language, disability, ethnicity, sexual orientation, gender identity, income level and geographic location. The Plan's response to requests for documents pertaining to these issues was a statement saying the Plan is in the process of obtaining National Committee for Quality Assurance (NCQA) for Health Equity Accreditation. Without further evidence of processes actually being implemented by the Plan to ensure staff and providers deliver services in a culturally competent manner, and without documentation of systems designed to identify, monitor and address disparities among the enrollee population, the Plan may perpetuate barriers to appropriate, effective behavioral health care.

Recommendations and Other Considerations

The Plan is encouraged to develop and implement comprehensive and effective programs for staff and participating providers to ensure behavioral health services are provided in a culturally competent manner that addresses the needs of the enrollee population. Effective programs ensure adequate training for staff and providers is furnished, monitored and documented. The Plan should also consider evaluating and documenting the effectiveness and the impact of the programs on enrollees and providers to further develop and improve cultural competency practices.

Enrollee and Provider Experience

20. <u>The Plan's credentialing and contracting process creates barriers to providing services to enrollees.</u>

Impacted Health Plans: Aetna Health of California Inc.

A streamlined and efficient credentialing and contracting process is key to expanding a health plan's provider network and ensuring that enrollees have timely access to behavioral health services. Delays during the credentialing and contracting process

create access to care roadblocks for enrollees as it restrains or limits the number of available providers in a health plan's network.

Interviews with providers indicated that Aetna Health of California Inc.'s credentialing process is lengthy and cumbersome due to infrequent responses from the Plan. Providers stated the credentialing and contracting process takes over a year to complete with frequent periods lasting weeks and sometimes months for the Plan to respond to provider inquiries.

Recommendations and Other Considerations

The Plan should consider improvements to streamline the current credentialing and contracting process to avoid delays in expanding the provider network. Possible improvements include proactive communication to keep providers informed of their application status and consistent check-ins with providers to ensure the contracting process is not stalled.

21. The Plan's online provider portal is difficult for providers to navigate.

Impacted Health Plans: Aetna Health of California Inc.

A health plan's online provider portal is critical for administrative efficiency, facilitating communication, and providing secure access to essential information for healthcare providers. Providers use the portal for a variety of administrative tasks including checking patient eligibility and claim status, submitting and tracking authorization requests, managing billing and accessing health plan documents.

During interviews with the Department, providers contracted with Aetna Health of California Inc. complained about difficulty navigating the Plan's online provider portal. According to one provider, the Plan's portal requires an unnecessary number of steps to determine enrollee and provider eligibility and it was difficult to verify co-insurance, co-pay and applicable Current Procedural Technology codes. Providers also reported that the portal was difficult to use and frequently provided inaccurate data.

Recommendations and Other Considerations

The Plan should develop strategies for ensuring all information, including benefits and claims information, on the provider portal is complete and accurate. Additionally, the Plan should consider providing education and training to providers regarding the use of the portal. The Plan should also gather provider feedback to increase provider satisfaction and efficiency.

22. The Plan failed to demonstrate it addressed poor provider satisfaction survey results.

Impacted Health Plan: Molina Healthcare of California

Provider satisfaction is crucial to developing and maintaining an adequate network of providers to deliver services to a health plan's enrollees. To assess provider satisfaction, health plans administer annual surveys to their network of providers that cover a range of topics, including, but not limited to, reimbursement practices, contract

fees, utilization management requirements and communication. Failure to implement changes to operational issues and challenges identified in provider surveys may result in providers leaving the network.

During Molina Healthcare of California's BHI, the Department did not find any evidence that the Plan was addressing issues identified in provider satisfaction surveys. According to documents reviewed, the Plan's providers had an overall satisfaction rate of 53.5% with the Plan's operational areas surveyed for 2022, putting the Plan in the 18.3% percentile with all commercial health plans' provider satisfaction in California for 2022. Specifically, the following areas were identified as requiring improvement:

- **Finance:** This surveyed area includes topics such as consistency of reimbursement rates according to contract fees and timeliness of claims process. Compared to 2021, provider satisfaction in this area worsened.

- **Utilization and Quality Management:** This surveyed area includes topics such as access to knowledgeable UM staff, authorization procedures, and access to care. Compared to 2021, provider satisfaction in this area worsened.

- **Network/Coordination of Care**: This surveyed area includes topics such as number of behavioral health providers in-network, quality of behavioral health providers, and communication with specialists. Compared to 2021, provider satisfaction in this area worsened.

Furthermore, the 2022 Provider Satisfaction Survey indicated only 8.4% of behavioral health care specialists responded to the survey, making it difficult for the Plan to accurately assess all issues and/or barriers its specialists may be experiencing. The Plan failed to provide evidence showing it made efforts to improve the areas identified as requiring improvement, nor did the Plan provide specific analysis related to behavioral health services.

Recommendations and Other Considerations

The Plan should consider methods for encouraging greater provider participation in surveys to understand provider concerns. The Plan should also gather provider feedback to increase provider satisfaction and efficiency.

CONCLUSION

The Department identified 39 separate Knox-Keene Act violations that in some instances, applied to multiple health plans. Additionally, through document review, interviews with the health plans and their delegates, as well as interviews with enrollees and providers, the Department identified 22 separate barriers to care, several of which were identified as applying to multiple health plans.

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

The identified violations and barriers to care impede enrollees' ability to obtain behavioral health services. Health plans are responsible for establishing operations, processes and procedures and business models that assist enrollees rather than hinder their access to care. Additionally, the results of the BHIs demonstrate that behavioral health providers experience barriers in attempting to provide timely and appropriate care. Health plans must make necessary changes to improve access to needed behavioral health care for all Californians.