DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

MOLINA HEALTHCARE OF CALIFORNIA

DATE: SEPTEMBER 25, 2025

Behavioral Health Investigation
Molina Healthcare of California

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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 Molina Healthcare of California (Plan) was included in Phase Three.

On October 16, 2023, the Department notified the Plan of its BHI covering the period of April 1, 2021 through May 31, 2023. 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 August 27, 2024 through August 29, 2024.

The BHI uncovered 16 Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Quality Assurance, and Grievances and Appeals.

1. The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services and through grievances and appeals.
2. The Plan's processes fail to ensure that enrollees are offered appointments within the timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments.
3. The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees.
4. The Plan lacks a process to conduct interrater reliability (IRR) testing for its behavioral health utilization management staff to ensure consistency in application of the nonprofit association (NPA) criteria and could not demonstrate such staff were achieving IRR pass rates of at least 90 percent.
5. The Plan is unable to demonstrate that all staff who conduct behavioral health utilization management reviews attended and completed the required formal training on nonprofit professional association (NPA) criteria.

[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.

6. The Plan is unable to demonstrate that its behavioral health utilization management staff consistently used the nonprofit professional association (NPA) criteria when required.
7. The Plan's policies and procedures for post-stabilization services are inconsistent with Knox-Keene Act requirements.
8. The Plan fails to consistently ensure appropriate discharge planning for enrollees.
9. 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.
10. The Plan does not adequately oversee its behavioral health triage and crisis line delegate.
11. The Plan fails to monitor and take effective action to correct identified timely access issues.
12. The Plan fails to ensure that credentialing applications for behavioral health providers are confirmed, assessed, and verified as required.
13. The Plan does not adequately monitor for trends in over and under-utilization of behavioral health care services.
14. The Plan fails to consistently and adequately consider all issues within enrollee grievances and provide rectification when appropriate.
15. The Plan's customer service staff fail to consistently identify enrollee expressions of dissatisfaction as grievances.
16. The Plan is operating at variance with its SB 855 compliance filing.

Additionally, the Department identified the following six barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Quality Assurance, and Grievances and Appeals.

1. The Plan does not provide its enrollees with easily accessible information about how to obtain routine, urgent, or emergent behavioral health care.
2. The Plan's lack of clarity as to which behavioral health services require prior authorization can cause enrollee and provider confusion.
3. The Plan's case management program does not actively assist enrollees in accessing behavioral health services.
4. The Plan failed to demonstrate it addressed poor provider satisfaction survey results.
5. 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.
6. The Plan does not have a system to accurately track and trend repeat callers having difficulty obtaining behavioral health appointments.

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 initiatives/operations resulting in positive impact on the Plan's provision of and/or enrollee access to behavioral health services.

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

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

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 medical 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, 2021 through May 31, 2023, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and CVS/Caremark 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

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the Department's Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. Despite the Department's attempt to engage Plan enrollees and providers in interviews for this BHI, the Department received no response from either Plan enrollees or providers willing to be interviewed.

PLAN BACKGROUND

Molina Healthcare of California obtained its Knox-Keene license in 1994 and is headquartered in Long Beach, CA. The Plan is a full-service health care service plan licensed to provide health care services to Medi-Cal, Medicare, Cal MediConnect, and commercial Covered California. The managed care plans include a health maintenance organization product. As of March 31, 2023, the Plan had 53,986[6] enrollees in its commercial lines of business. The Plan operates in Imperial, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, and San Diego Counties.

[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.
[6] Source: DMHC Dashboard 2023, Quarter 1.

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services and through grievances and appeals.

Statutory/Regulatory Reference(s): Section 1367.27(j)(3), (o)(1) and (o)(2)(B)

Supporting Documentation:

- Plan *Provider Online Directory Procedure* (February 4, 2024)
- Plan *iServe Request for Provider Online Directory (POD) Data Inaccuracy Correction Job Aide* (Undated)
- *Molina Healthcare of California Marketplace Provider Manual 2023* (Last Update: January 1, 2023)
- *Molina Healthcare of California Marketplace Provider Manual 2022* (Last Update: August 2022)
- *Molina Healthcare of California Marketplace Provider Manual 2021* (Last Update: May 2021)
- Plan *California Provider Online Directory Inaccuracy Report* (April 1, 2021 to May 31, 2023)
- Plan *Member Grievance Process (Marketplace)* (May 31, 2022)
- Plan *Member Grievance Process Defining and Identifying Grievances MP,-* Document Request 76 (September 10, 2024)
- 56 Plan Inquiry Files (April 1, 2021 through May 31, 2023)
- 25 Plan Grievance and Appeal Files (April 1, 2021 through May 31, 2023)
- *Molina Audit Memo* (September 6, 2024)

Assessment: If the Plan is notified of a potential provider directory inaccuracy, it is required to promptly investigate a reported inaccuracy, and, if necessary, undertake corrective action within 30 business days of receipt of the report by either verifying the accuracy of the information or updating the information to ensure the accuracy of the directory or directories.[7] Moreover, the Plan must document the receipt and outcome of each reported inaccuracy, including any updates or changes made to its directory or directories.[8]

Policies and Procedures

The Plan's *Provider Online Directory (POD)* procedure outlines the Plan's procedure for ensuring the Plan's online provider directory contains an accurate and current listing of its credentialed and contracted providers and facilities. The procedure states the Plan monitors its POD for accuracy by conducting daily monitoring, quarterly reviews, and outbound call campaigns.

[7] Sections 1367.27(j)(3) and (o)(1)
[8] Section 1367.27(o)(2)(B)

The Plan's *iServe Request for POD Data Inaccuracy Correction* job aid describes the Plan's process for its customer service representatives to submit a provider directory inaccuracy report. The document outlines the 21 steps required to submit a report of a potential provider directory inaccuracy to the Provider Relations and the Provider Contracting departments. The job aid states that it should only be followed when customer service representatives are informed of an error in the POD and the enrollee/caller does not want to submit a correction through the POD using the provider data correction form. The customer service representative is supposed to ask for certain information from the enrollee/caller, such as the line of business they are covered under and the provider's name. The job aid also instructs the customer service representative to follow the grievance procedure if an enrollee calls about a discrepancy in the POD and expresses dissatisfaction.

The Plan's *Member Grievance Process (Marketplace)* and *Member Grievance Process Defining and Identifying Grievances* describes the Plan's grievance process in general and identifies "Provider Directory Inaccuracies" as a standard grievance that is subject to grievance review.

The Department's review of the Plan's Provider Manuals from 2021 to 2023 found that each manual delineated the Plan's requirement for its providers to ensure the accuracy of their individual provider directory entries and outlined the steps required to validate and update their individual directory entries.

The Plan submitted a report of the Plan's efforts to track, verify, and resolve reported directory inaccuracies.[9] However, review of the Plan's call center files and call log demonstrated that enrollees reported numerous potential provider directory inaccuracies that were not tracked, investigated or resolved.

Interviews

The Plan's Director of Provider Data Management provided a description of how the Plan monitors its directory, including making daily updates with changes from the previous day, obtaining provider attestations every 90 days to validate directory information and whether they are accepting new patients, using a secret shopper program and deploying a third-party provider website screener. The Plan also requires its call center employees to notify Molina's Provider Directory Maintenance team of potential provider directory inaccuracies by initiating an iServe ticket anytime an enrollee reports a potential directory inaccuracy and to document the iServe ticket number in the call log.

File Review

The Department reviewed 53[10] call inquiry files and the case notes or call audio recordings indicated that in ten[11] files (19%) there was a report of directory inaccuracies. Zero (0%) of these files had notes indicating a provider directory

[9] Plan Provider Online Directory Procedure (February 4, 2024)
[10] The Department reviewed 56 Behavioral Health Provider Network Call Inquiry Files. Three files (PN Call Inquiry Files 34-36) were excluded for lack of audio recordings and inadequate written case notes.
[11] Plan Inquiry Files: LFC_PNI Files: 13, 16, 17, 37, 42-44, 48, 51, 56.

inaccuracy was reported by submitting an iServe ticket or that a grievance was filed to escalate the issue to the Plan's appeals and grievances department.

The Department reviewed a random sample of 25 grievance and appeal files categorized as Access and Availability grievances. Of the 25 files, 13 of the files[12] (52%) were related to provider directory inaccuracies.

Case Examples

- **LFC_PNI File #1:** The enrollee called the Plan and requested assistance to locate a psychiatrist because the providers listed in the provider directory in the enrollee's zip code were not accepting new patients. The enrollee mentioned calling multiple times in the past few months with the same issue. A case manager assisted the enrollee with obtaining an appointment scheduled for two months after the call. The query was not treated as a provider directory inaccuracy and the file did not include an iServe ticket number for the providers listed in the directory who were not accepting new patients.

- **LFC_PNI File #3:** The enrollee called the Plan seeking an inpatient rehabilitation facility for the enrollee's child but had "gotten the run around" with the list of providers sent from a provider search. Specifically, one facility was outpatient rather than inpatient, another facility did not accept Molina, and another facility informed the enrollee that the child would have to see the primary care physician (PCP) to get prior authorization before obtaining services. The enrollee noted that the child had already seen the PCP and it had not worked. The call was escalated to a case manager resulting in the enrollee terminating coverage with Molina. The query was not treated as a provider directory inaccuracy and the file did not include an iServe ticket number for the providers listed in the directory who were no longer contracted with Molina.

- **LFC_PNI File #5:** The enrollee called the Plan seeking a psychologist who accepted Molina Marketplace but had been given three provider lists with providers who no longer accepted Molina Marketplace. Ultimately, the enrollee obtained an appointment six days later. The enrollee noted calling the Plan several weeks prior and was told that the agent would help get a prior authorization for a non-participating provider. However, the system showed that the enrollee called for a network inquiry. The query was not treated as a provider directory inaccuracy and the file did not include an iServe ticket number for the providers listed in the directory who were no longer accepting enrollees with Molina Marketplace.

[12] LFF_AA Files: 1, 2, 3, 4, 5, 6, 8, 15, 17, 18, 21, 22, 23.

The Department requested a report[13] of any iServe tickets documenting directory inaccuracy for the specific Access and Availability Behavioral Health grievance files in the above-referenced case files. In response, the Plan stated, "The Plan reviewed the iServe report against the above submitted grievance files and found that no tickets were submitted by the assigned A&G specialist for any of the grievance files."

Conclusion: Although the Plan maintains a procedure, internal job aids and reports addressing provider directory inaccuracies, a review of the Plan's grievance logs and call inquiry files demonstrated that the Plan did not consistently identify, investigate, resolve and document potential provider directory inaccuracies. Therefore, the Department finds the Plan in violation of Sections 1367.27(j)(3), 1367.27(o)(1) and 1367.27(o)(2)(B).

#2: **The Plan's processes fail to ensure that enrollees are offered appointments within the timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments.**

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), (a)(5)(D), (E), 1368(a)(1) and Rule 1300.67.2.2(b)(2), (c)(5)(D), (E)

Supporting Documentation:

- Plan *Timely Access to Care* (April 21, 2023)
- Plan *Member Grievance Process* (May 31, 2022)
- Plan *Case Management (Medi-Cal & Marketplace)* (May 28, 2024)
- 25 Plan Standard Grievance Files (April 1, 2021, through May 31, 2023)
- Plan Claims Log H (April 1, 2021, through May 31, 2023)

Assessment: Plan grievance systems must have reasonable procedures to ensure that enrollee grievances are adequately considered and rectified when appropriate.[14] A grievance is considered resolved when the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system.[15] A grievance regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.[16]

When an enrollee requests a behavioral health appointment, the Plan is required to offer appointments within specified timely access standards, with limited exception.[17] The timeframe for appointments depends on the urgency of the service needed and the type of service.[18] Non-urgent appointments with a non-physician mental health

[13] Plan Response to DMHC Request #88.
[14] Section 1368(a)(1).
[15] Rule 1300.68(a)(4).
[16] Section 1368(a)(1); Rule 1300.67.2.2(b)(2).
[17] The exception to timely appointment requirements includes cases in which the referring or treating provider, or the triaging provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. In such cases, the waiting time for an appointment may be extended (Section 1367.03(a)(5)(H)).
[18] Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5).

provider must be provided within 10 business days of the request, and non-urgent appointments with specialty care physicians within 15 business days of the request.[19] Urgent appointments that do not require prior authorization must be offered within 48 hours of the request for an appointment. Urgent appointments that require prior authorization must be offered within 96 hours of the request for an appointment. [20] Follow-up appointments with a non-physician mental health or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment.[21]

Therefore, when an enrollee notifies a health plan they are having difficulty obtaining a behavioral health appointment or are experiencing delays in scheduling an appointment, the plan must consider the expression of dissatisfaction as a grievance and an initial request for an appointment. When a request for an appointment is made, the plan is required to offer an appointment within the applicable timely access standards. Failure to do so means the plan has not adequately considered and rectified or resolved the grievance. Adequate consideration and resolution require offering the enrollee an appointment within timeliness standards because obtaining an appointment was the substance of the grievance.

Policies and Procedures

Review of the Plan's documents, including policies and procedures, call logs, and grievance files, demonstrated that the Plan's processes fail to ensure enrollees are offered appointments within the timely access standards when enrollees expressed difficulty in finding an in-network behavioral health provider. The Plan's *Timely Access to Care* policy includes the statutory timeline standards for the various urgent and non-urgent appointment types. The Plan's *Case Management (Medi-Cal & Marketplace)* policy describes the Plan's Case Management program and the Plan's *Member Grievance Policy* describe the Plan's grievance processes in general. However, none of the policies describe a process for offering enrollees timely appointments when enrollees file grievances involving delays or difficulties finding an appointment. Review of the grievance files revealed a pattern of the Plan assigning an enrollee a case manager when an enrollee files a grievance involving delays or difficulties finding an appointment, and a failure of that process to offer the enrollee a timely behavioral health appointment.

Interviews

The Department asked the Plan how it identified enrollees for referral to its Case Management program. The Plan's Vice President of Healthcare Services stated that it can be triggered in a variety of ways, from "provider referral to a risk stratification report." The Department asked the Plan to describe its process when an enrollee has called multiple times expressing that they have had difficulty obtaining a behavioral health appointment. The Plan's Manager of Appeals and Grievances stated that this

[19] Section 1367.03(a)(1); Rule 1300.67.2.2(c)(5)(D) & (E).
[20] Section 1367.03(a)(5)(A), (B).
[21] Section 1367.03(a)(5)(F)

would be escalated to a grievance and a referral would be made to the Case Management team.

File Review

The Department reviewed 20 randomly selected behavioral health standard grievance files categorized by the Plan as Access and Availability issues. Of those, in 15 files (75%) there was no documentation indicating the enrollees were offered behavioral health appointments within the timely access standards. Furthermore, in eight[22] of the 20 files (40%), the enrollees did not appear to have obtained an in-network behavioral health appointment based on available claims data.[23] In 17[24] of 20 (85%) files, the enrollees were referred to Case Management for further assistance in obtaining a behavioral health appointment. Of those 17 files, only 2 files (12%) demonstrated an enrollee was offered an appointment within the timely access standards.

Case Examples

- **LFF_AA File #1:** The enrollee called the Member Contact Center on September 27, 2021. The case notes state, "Mbr is really upset b/c they have called in multiple times within the last few months needing assistance w/ finding a psychiatrist. Providers listed in the provider directory are not accepting any new patients at this time." The agent on the call advised the enrollee that they would be filing a grievance, and that the enrollee should receive a resolution within 30 calendar days. The enrollee was assigned to a Case Manager on September 29, 2021. The Case Manager notes in the file indicate that the Case Manager identified a telehealth provider, and that the enrollee was able to secure an appointment with the telehealth provider in November.[25] On October 7, 2021, a grievance resolution letter was sent to the enrollee stating that the enrollee had spoken to their Case Manager on October 4, 2021, that the enrollee had a telehealth appointment scheduled for therapy in "November," and that the Plan would continue to try and find the member an in-person provider. The Department's review of the claims data showed that the enrollee did not attend a behavioral health appointment until February 15, 2022, 92 business days after the enrollee contacted the Plan requesting assistance in finding a psychiatrist.

The November telehealth appointment was beyond the timely access standards and the grievance file did not include any evidence the Plan offered the enrollee an appointment within those standards. As such, this file demonstrates that the Plan's grievance process failed to offer the enrollee an appointment with a psychiatrist, a specialty physician, within 15 business days of the request.[26]

[22] LFF_AA Files: 13, 15-17, 11, 22, 23.
[23] LFF_AA File: 10.
[24] LFF_AA Files: 1-6, 10, 12, 14-17, 21-25.
[25] It is unclear whether the case manager offered the enrollee the November appointment with the telehealth provider, or if the enrollee called and scheduled the appointment themselves.
[26] Section 1367.03(a)(5)(D); Rule 1300.67.2.2(c)(5)(D).

- **LFF_AA File #14:** The enrollee called the Member Contact Center on March 7, 2022. The case notes state the enrollee had been waiting for a referral for behavioral health for over four months, and that their provider confirmed they submitted the referral. It was further noted that the enrollee had been "back and forth" with Molina trying to get help and information on their behavioral health benefits. The agent on the call confirmed that the enrollee's primary care physician had sent the referral, and then the agent advised the enrollee of whom to call next for further assistance. At that point, the enrollee disconnected from the call, in apparent frustration. The agent then escalated the issue to a grievance and the enrollee was assigned to a Case Manager on March 9, 2022. The enrollee spoke to the Case Manager on March 11, 2022. The grievance resolution letter was sent on March 19, 2022, and the enrollee was given several providers to call for an appointment. The Department's review of claims data[27] showed that the enrollee obtained an appointment on April 7, 2022, 23 business days from the date the enrollee called the Plan for assistance.

The grievance file did not include any evidence the Plan offered the enrollee an appointment within the timely access standard of 10 business days for a non-urgent appointment with a non-physician behavioral health provider.[28]

- **LFF_AA File #21:** The enrollee called the Member Contact Center on August 1, 2022, after having difficulty obtaining a psychiatrist appointment. The case notes state the enrollee had called the psychiatrists in the Plan's provider directory and none of them were part of the Plan's provider network. The agent handling the call referred to the directory and determined that the enrollee's findings were correct, and none of the providers listed accepted Molina coverage. The agent then escalated the call to a grievance and advised the enrollee that they would get a resolution within 30 days. The enrollee was referred to Case Management on August 3, 2022. The enrollee spoke with a Case Manager on August 5, 2022, and they provided the enrollee with a new list of providers to call for an appointment. The Department's review of claims data[29] found the member obtained an appointment on October 10, 2022, 49 business days from the time the enrollee initially contacted the Plan with this issue.

The grievance file did not include any evidence that the Plan offered the enrollee an appointment with a psychiatrist, a specialty physician, within 15 business days of the request.

[27] Log H.
[28] Section 1367.03(a)(5)(E): Rule 1300.67.2.2(c)(5)(E).
[29] Log H.

TABLE 1

Access and Availability Grievances

FILE TYPE	NUMBER OF FILES	LEGAL REQUIREMENT	COMPLIANT	DEFICIENT
Standard Behavioral Health Grievance and Appeal Files Categorized as Access and Availability	20	The Plan arranges for covered non-urgent behavioral health appointments in compliance with the timely access standards	5 (25%)	15 (75%)

Conclusion: Review of the Plan's grievance case files demonstrated the Plan's process of steering enrollees with difficulty accessing behavioral health appointments through the standard grievance system and referring them to Case Management as a means of resolution, fails to ensure the enrollee is offered an appointment within the timely access standards. The Plan thereby fails to adequately consider and rectify enrollee grievances seeking behavioral health appointments. Therefore, the Department finds the Plan in violation of Sections 1367.03(a)(1), and (a)(5)(D), (E), 1368(a)(1) and Rule 1300.67.2.2(b)(2), and (c)(5)(D), (E).

#3: The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), (a)(5)(A), (B), (C), (D), (E) and (F), 1374.72(d), and Rule 1300.67.2.2(c)(1)

Supporting Documentation:

- Agreement and Combined Evidence of Coverage and Disclosure Form 2021
- Agreement and Combined Evidence of Coverage and Disclosure Form 2022
- Agreement and Combined Evidence of Coverage and Disclosure Form 2023
- Plan's *Network Adequacy, Availability and Accessibility* (August 10, 2023)
- Plan's *Coordination of Care and Referral Procedure for Behavioral Health Services Policy* (May 22, 2023)
- 8 Plan UM Denial and Modification Files (April 1, 2021 through May 31, 2023)
- 3 In-Depth Enrollee Files (April 1, 2021 through May 31, 2023)
- 39 Files of Follow Up after contact with Behavioral Health Crisis Line (April 1, 2021 through May 31, 2023)
- 25 Grievance and Appeal files (April 1, 2021 through May 31, 2023)

Assessment: Health plans are required to arrange for covered behavioral health care services in a timely manner appropriate for the enrollee's condition and shall ensure that its network of providers has adequate capacity to offer enrollees appointments,

including follow-up appointments, within specified timeframes.[30] If behavioral health services are not available within geographic and timely access standards then the Plan shall arrange for out-of-network services.[31]

Policies and Procedures

The Plan's Agreement and Combined Evidence of Coverage and Disclosure Form[32] (Evidence of Coverage or EOC) for 2021, 2022, and 2023 restates the Plan's obligation to arrange for out-of-network medically necessary behavioral health care when services are not available in-network. The EOCs do not describe a specific process for how the Plan would arrange for and cover the services of a non-participating Behavioral Health provider. Further, while the Plan's *Network Adequacy, Availability and Accessibility* and *Coordination of Care and Referral Procedure for Behavioral Health Services Policy* reference its obligation to arrange for out-of-network behavioral health care services when in-network services are not available within geographic and timely access standards, none specifically describes how the Plan performs these functions.

File Review

The Department reviewed a random sample of 35[33] Utilization Management denial files. Of these files, eight [34] (23%) of the files involved an out-of-network provider request for care. There was no evidence in these files showing that the Plan assisted the enrollee in getting an appointment within the timely access standards in-network and did not arrange for medically necessary out-of-network service.

The Department also reviewed five in-depth enrollee files. Each of these files included all documents related to an enrollee trying to obtain behavioral health services. Of these five files, three[35] (60%) of the files involved enrollees who expressed difficulties with obtaining in-network providers, and there was no evidence in these files that the Plan assisted the enrollee in getting an appointment within the timely access standards in-network and did not arrange for medically necessary out-of-network service.

The Department reviewed a random sample of 25 grievance and appeals files categorized as Access and Availability. In 16[36] of the files (64%), the enrollee was having difficulty obtaining an appointment with a behavioral health provider and Plan staff failed to assist the enrollee in obtaining an appointment within the timely access standards in-network and did not arrange for medically necessary out-of-network services.

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[30] Section 1367.03(a)(1) and (a)(5)(A)(B)(C)(D) and (E).
[31] Section 1374.72(d).
[32] See page 23 in the 2021 and 2022 versions and page 24 in the 2023 version.
[33] Utilization Management Files: LFA_BHUM Files: 1-4, 6-8, 11-12, 15, 20, 23-24, 30-32, 36, 40-41, 44, 46-47, 50-51, 53-54, 56-57, 61-63, 69, 72, 77, 79, 83.
[34] LFA_BHUM Files: 3, 6, 7, 23, 30, 44, 51, 54.
[35] In-Depth Files: 1, 2, 4.
[36] LFF_AA Files: 1-4, 8, 10, 11, 13-15, 17, 21-25.

Case Examples

- **LFF_AA #21:** The enrollee called the Member Contact Center on August 1, 2022, reporting they called providers listed in the Plan's directory, but none were taking Molina. In this file, the grievance and appeal (GA) specialist documents calling all the providers on the list and confirming they are all out-of-network with Molina. The GA specialist advised enrollee that the out-of-network provider may send a prior authorization request to Molina and created a grievance for the member and advised the turnaround time for this is 30 days. This file demonstrates that the Plan failed to offer an appointment with an in-network provider within the timely access standards and failed to arrange for out-of-network services in violation of the Knox-Keene Act.[37]

- **LFF_AA #23:** The enrollee called the Plan on July 23, 2021, reporting this was the third call to the Plan trying to find a psychologist. The enrollee reported the first call was disconnected and second call was on hold over 30 minutes. The Plan staff documented calling ten doctors, and no one had an available appointment until "late August, late September and mid-October". The enrollee had already filed a complaint due to frustration with the network and was requesting help finding a doctor or seeing an out-of-network provider with a prior authorization request. The Plan staff added the enrollee to a provider wait list that had no availability for 4-8 weeks and advised the enrollee they would need a referral from their PCP to see an out-of-network provider. This file demonstrates that the Plan failed to offer an appointment with an in-network provider within the timely access standards and failed to arrange for out-of-network services in violation of the Knox-Keene Act.[38] Further, the claims data reviewed shows the enrollee never received service.

Conclusion: The Plan's EOCs and policies[39] indicate the Plan will arrange for out-of-network care when in-network services are not available within geographic and timely access standards. However, the Department's file review demonstrated the Plan either denied enrollee out-of-network requests or did not arrange for out-of-network care when in-network appointments were not available within timely access standards. Therefore, the Department finds the Plan in violation of Sections 1367.03(a)(1), (5)(A) – (F), 1374.72(d), and Rule 1300.67.2.2(c)(1).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING:

#4: The Plan lacks a process to conduct interrater reliability (IRR) testing for its behavioral health utilization management staff to ensure consistency in application of the nonprofit association (NPA) criteria and could not demonstrate such staff were achieving IRR pass rates of at least 90 percent.

[37] Section 1367.03(a)(5)(D); 1374.72(d); Rule 1300.67.2.2(c)(5)(D).
[38] Section 1367.03(a)(5)(D); 1374.72(d); Rule 1300.67.2.2(c)(5)(D).
[39] *Network Adequacy, Availability and Accessibility and Coordination of Care and Referral Procedure for Behavioral Health Services Policy.*

Statutory/Regulatory Reference(s): Section 1374.721(e)(5), (6) and (7)

Supporting Documentation:

- Plan Policy *CA-HCS-366 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* (February 15, 2023)
- Plan Procedure *CA-HCS-366.01 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* (February 4, 2023)
- *2022 Molina Healthcare Inter-Rater Reliability Analysis - California Healthcare Services Summary* (July 1, 2022)
- *2023 Molina Healthcare Inter-Rater Reliability Analysis - California Healthcare Services Summary (April 5, 2023)*
- Post Interview Document Request sent to the Plan on August 28, 2024, narrative response to Document Request #100 dated September 6, 2024
- Post Interview Document Request sent to the Plan on September 23, 2024, narrative response to Document Request #121

Assessment: The Plan is required to conduct interrater reliability (IRR) testing on its behavioral health utilization management staff to ensure consistency in application of the nonprofit professional association (NPA) criteria. The Plan's utilization management staff are required to score a passing rate of at least 90 percent and if not, the Plan shall provide immediate remediation.[40]

Policy and Procedures

The Plan's *Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* policy (*Interrater Reliability Policy*) defines the IRR requirements and describes how the Plan administers its IRR testing. *Interrater Reliability Policy* states that it includes IRR testing "in accordance with H&S Code Section 1374.721(e)(7)," and that any scores less than 90% will result in "immediate remediation." The *Interrater Reliability Policy* does not specify whether California-specific or behavioral health-specific scenarios are used in the IRR testing. Also, the *Interrater Reliability Policy* does not describe a process for running IRR reports about how NPA clinical guidelines are used by behavioral health utilization management staff in conjunction with the utilization management process and parity compliance activities as required.[41] The Plan's *Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* procedure similarly states that IRR testing is conducted "in accordance with H&S Code Section 1374.721(e)(7)." However, the procedure also states that the compliance threshold for medical directors and pharmacists is 80%, which is inconsistent with the 90% compliance threshold required in Section 1374.721(e)(7).[42]

The Plan's *2022 Molina Healthcare Inter-Rater Reliability Analysis – California Healthcare Services Summary (2022 IRR Results)* describes a compliance threshold

[40] Sections 1374.721(e)(5)-(7).
[41] Section 1374.721(e)(6).
[42] Shortly prior to issuance of the Plan's BHI Report the Plan filed revised IRR policies and procedures with the Department (efiling # 20253530) to reflect the statutorily required IRR compliance threshold score of 90% for all utilization management staff.

of 80% for the Plan's medical directors and nurse utilization management staff. This policy stated that cases reviewed focused on inpatient stays, prior authorization, durable medical equipment, home health, behavioral health, transplant, imaging, and post-acute settings for Medicaid and Marketplace. The report did not indicate whether any behavioral health files were used for the testing scenarios, nor were any of the Plan's behavioral health utilization management staff evaluated. The cases used were hypothetical and stated that the clinical criteria used were Milliman Care Guidelines (MCG), Molina Clinical Policy, Molina Clinical Review, Medicaid criteria, and did not mention the NPA criteria.[43]

The *2023 Molina Healthcare Inter-Rater Reliability Analysis – California Healthcare Services Summary (2023 IRR Results)* describes the Plan's evaluation method for utilization management test cases and includes a compliance threshold of greater than or equal to 90%. However, like the *2022 IRR Results*, this report did not indicate that any behavioral health files were used nor were any of the Plan's behavioral health utilization management staff evaluated.

Interviews

During interviews, the Plan's Chief Medical Officer described the IRR testing process. They could not confirm that behavioral health cases were included in the IRR process during the review period, but the Plan stated it adjusted the case selection process to include at least one behavioral health case since the review period.

Following the interviews, the Department requested the Plan provide a written description of the IRR process discussed in interviews, including the specifics on the individual testing and pass rates and the specifics on the group testing and pass rates.[44] The Plan's written response did not describe whether the Plan conducts IRR testing on its behavioral health utilization management staff to ensure consistency in application of the NPA criteria.

The Plan's *2022 IRR Results* demonstrates non-compliance with the Knox-Keene Act because it included a minimum pass rate of 80% for utilization management staff instead of the required 90%.[45] Furthermore, the Plan used hypothetical cases and did not include the use of the NPA criteria on any of the hypothetical cases, nor did the Plan review any behavioral health cases when conducting IRR testing as required.[46] Although the *2023 IRR Results* included a minimum pass rate of greater than or equal to 90%, the Plan still did not include the use of the NPA criteria and did not include any behavioral health cases.

Conclusion: Based on review of the Plan's submitted documentation and information provided by the Plan during interviews, the Department found the Plan did not have an IRR process in place to test the IRR of its behavioral health utilization management staff to ensure consistency in the application of the NPA criteria. In addition, because

[43] Section 1374.721(e)(6).
[44] DMHC Document Request #120.
[45] Section 1374.72(e)(7).
[46] Sections 1374.72(e)(5) & (6).

the Plan did not produce any IRR reports on its behavioral health utilization management staff, the Plan could not demonstrate its staff met the minimum pass rates of 90%. Despite multiple requests for information, the Plan failed to provide any evidence of a compliant IRR testing process. Therefore, the Department finds the Plan in violation of Section 1374.721(e)(5), (6) and (7).

#5: <u>The Plan is unable to demonstrate that all staff who conduct behavioral health utilization management reviews attended and completed the required formal training on nonprofit professional association (NPA) criteria.</u>

Statutory/Regulatory Reference(s): Section 1374.721(b) and (e)(1)

Supporting Documentation:

- Plan memo dated June 3, 3024[47]
- Plan Policy CA-HCS-365 *Clinical Criteria for Utilization Management Decision Making* (March 29, 2024).
- Plan Procedure CA-HCS-365 *Clinical Criteria for Utilization Management Decision Making* (March 29, 2024).
- Plan memo in response to Document Request #28 (6/28/24)
- Plan *Training Roster SB 855* (undated)
- 12 Plan UM Denial, Delay and Modification Files[48] (April 1, 2021 through May 31, 2023)
- 13 Plan UM Approval Files[49] (April 1, 2021 through May 31, 2023)

Assessment: The Plan is required to apply the clinical criteria and guidelines created and developed by the NPA for the relevant clinical specialty when conducting utilization review of behavioral health care services.[50] To ensure that the Plan properly uses and applies the clinical criteria, the Plan shall sponsor a formal education program by the nonprofit clinical specialty associations to educate the health care service plan's staff who review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.[51]

<u>Policy and Procedures</u>.

The Plan has both a policy and a procedure titled *Clinical Criteria for Utilization Management Decision Making* that states staff are trained in the use and application of the most recent NPA clinical criteria and guidelines before they conduct any utilization management of behavioral health care services. However, despite these policies, file review demonstrated that in practice not all Plan staff are trained on the use of the NPA clinical criteria.

The Department requested the Plan provide training dates, an attendee roster, and other evidence of training for the Plan-sponsored NPA formal education program. In

[47] BHIUM3 a-c.
[48] LFA_BHUM.
[49] Log A FP 1.
[50] Section 1374.721(b).
[51] Section 1374.721(e)(1).

response,[52] the Plan provided a copy of its SB 855 Training Roster and stated it began trainings in 2021, with several trainings available on a self-paced schedule.

The Plan's SB 855 Training Roster is an undated document that includes a table with the names of staff, their role and titles, as well as corresponding reference to specific NPA training criteria.[53] For many staff listed in the document it was indicated either that completion dates were unknown, training was in progress, completion status was unknown or no notation was included.

File Review

The Department reviewed a random sample of 35 utilization management denial files. Of these 35 files, 12[54] (34%) files involved requests for which the use of NPA criteria would apply. The Department found that in all 12 files (100%), the reviewers making the utilization management decisions were not trained on NPA criteria according to the SB 855 Training Roster provided by the Plan.

The Department also reviewed a random sample of 13 utilization management approval files. All 13[55] files involved requests for which the use of NPA criteria would apply. The Department found in 12[56] of the 13 files (92%), the reviewers making the decisions were not trained on NPA criteria and utilized non-NPA criteria in their decision-making.

Case Examples

- **LFA_BHUM File#56:** On December 23, 2022, a request was submitted for acute inpatient hospitalization for treatment related to a diagnosis of anorexia nervosa under an involuntary hold. The nurse reviewer who evaluated the request had not been trained on the use of NPA criteria according to the SB 855 Training Roster provided by the Plan. The file indicates the nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to a medical director for review. Even though the Medical Director had been trained on the use of NPA criteria according to the SB 855 Training Roster, they still did not apply the NPA criteria and denied the request.[57]

- **LFA_BHUM File #62:** On February 22, 2023, a request was submitted for acute inpatient hospitalization for treatment related to a diagnosis of catatonic disorder. The nurse reviewer who evaluated the request had not been trained

[52] Memo in response to Document Request #28 (6/28/24).
[53] NPA criteria listed in the SB 855 Training roster includes: American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Service Intensity Instrument (ESCII), VA Department of Defense, and APA. The VA Department of Defense is not an NPA but developed a clinical guideline that Plan has approval to use.
[54] LFA_BHUM Files: 7, 11, 23, 30, 31, 40, 46, 50, 53, 56, 61, and 62.
[55] Log A FP 1 Files: 1, 2, 3, 4, 7, 8, 10, 14, 17, 21, 27, 37, and 47.
[56] Log A FP 1 Files 1, 2, 3, 4, 7, 8, 10, 14, 17, 21, 27, and 37.
[57] The MD, although NPA-trained, used non-NPA clinical criteria to deny the requested acute inpatient admission. This case example is included in the write-up for Violations # 4 & 6.

on the use of the NPA criteria according to the SB 855 Training Roster provided by the Plan. The file indicates the nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to the medical director for review. Even though the Medical Director had been trained on the use of NPA criteria according to the SB 855 Training Roster, they still did not apply the NPA criteria and denied the request.[58]

- **Log A FP 1 File #4:** On February 16, 2023, a request was submitted for acute inpatient hospitalization for treatment related to a diagnosis of major depressive disorder and substance detoxification under an involuntary hold. The nurse reviewer who evaluated the request was not listed on the SB 855 Training Roster provided by the Plan. The file indicates the nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to the medical director for review. Even though the Medical Director had been trained on the use of NPA criteria according to the SB 855 Training Roster, they still did not apply the NPA criteria and denied the request

Conclusion: Although the Plan has policies and procedures[59] that describe training on the NPA criteria, file review demonstrated Plan staff were making utilization management decisions without any documented evidence of having been trained in the use of the NPA criteria. Therefore, the Department finds the Plan in violation of Section 1374.721(b) and (e)(1).

#6: The Plan is unable to demonstrate that its behavioral health utilization management staff consistently use the nonprofit professional association (NPA) criteria when required.

Statutory/Regulatory Reference(s): Section 1374.721(b)

Supporting Documentation:

- Plan Policy CA-HCS-365 *Clinical Criteria for Utilization Management Decision Making (March 29, 2024)*
- Plan Procedure CA-HCS-365.01 *Clinical Criteria for Utilization Management Decision Making (March 29, 2024)*
- Plan Procedure CA-HCS-365.01 *Clinical Criteria for Utilization Management Decision Making* State Addendum *(March 29, 2024)*
- 12 Plan UM Denial, Delay and Modification Files[60] (April 1, 2021 through May 31, 2023)
- 13 Plan UM Approval Files[61] (April 1, 2021 through May 31, 2023)

Assessment: In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, the Plan is required to apply the

[58] The MD in this case file also inappropriately denied the requested inpatient hospitalization using non-NPA clinical criteria. This example is included in the write-up for Violation # 6.
[59] *Clinical Criteria for Utilization Management Decision Making Policy and Procedure.*
[60] LFA_BHUM.
[61] Log A FP 1.

criteria and guidelines set forth in the most recent versions of treatment criteria developed by the NPAs for the relevant clinical specialty.[62]

Policies and Procedures

The Plan's *Clinical Criteria for Utilization Management Decision Making* and *Clinical Criteria for Utilization Management Decision Making State Addendum* policy includes a requirement that the State Regulations and State Specific Criteria Guideline Sets, including NPA criteria, are to be used. The Plan's procedure, *Clinical Criteria for Utilization Management Decision Making,* establishes the appropriate review, use, availability, and application of objective evidence-based clinical criteria to determine medical necessity and appropriateness of requested services. Despite these policies, file review revealed that in practice the Plan is not applying the NPA criteria on a consistent basis.

File Review

The Department reviewed a random sample of 35 utilization management denial files.[63] Of these 35 files, the Department determined 12[64] (34%) files involved requests for which the use of the NPA criteria would apply. The Department found that guidelines other than NPA criteria were used to evaluate all (100%) of these requests. The Department also reviewed a random sample of 13 utilization management approval files. All 13[65] (100%) files involved requests for which the use of NPA criteria would apply where Department found guidelines other than NPA criteria were used to evaluate these requests.

Case Examples

- **Log A FP 1 File #4:** On February 16, 2023, a request was submitted for acute inpatient hospitalization for treatment related to a diagnosis of major depressive disorder and substance detoxification under an involuntary hold. The nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to a medical director for review. The physician utilized MCG for the review instead of LOCUS or ASAM and denied the request.

- **LFA_BHUM File #61:** On February 22, 2023, a request was submitted for inpatient care following an emergency department visit for issues related to substance abuse. The nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to a medical director for review. The medical director utilized MCG for the review instead of LOCUS or ASAM and denied the request.

[62] Section 1374.721(b).
[63] LFA_BHUM.
[64] LFA_BHUM Files: 7, 11, 23, 30, 31, 40, 46, 50, 53, 56, 61, and 62.
[65] Log A FP 1 Files: 1, 2, 3, 4, 7, 8, 10, 14, 17, 21, 27, 37, and 47.

- **LFA_BHUM File #62:** On February 22, 2023, a request was submitted for acute inpatient hospitalization for treatment related to a diagnosis of catatonic disorder. The nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to the medical director for review. The medical director utilized MCG for the review instead of LOCUS and denied the request.

- **Log A FP 1 File #47:** On September 6, 2022, a request was submitted for treatment at a Residential Treatment Center for substance abuse. The nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to a medical director for review. The medical director applied the correct NPA criteria, ASAM, and approved the request.

- **LFA_BHUM File #56**: On December 23, 2022, a request was submitted for inpatient care for the treatment of anorexia, schizophrenia, and psychosis. The nurse reviewer applied MCG criteria and upon determining the request did not meet medical necessity criteria, escalated it to the medical director for review. The medical director applied MCG for review instead of LOCUS and denied the request.

Conclusion: The Plan's policies and procedures[66] include a requirement that the NPA criteria are to be used for all behavioral health utilization management decisions. However, the Department's file review showed the Plan's staff was not utilizing the NPA criteria in evaluating behavioral health service requests as required by the Knox-Keene Act. Therefore, the Department finds the Plan in violation of Section 1374.721(b).

#7: The Plan's policies and procedures for post-stabilization services are inconsistent with Knox-Keene Act requirements.

Statutory/Regulatory Reference(s): Sections 1371.4(d), (j)(1) and (j)(2)(B) and 1262.8(b)(3), (d)(1), (d)(2) and (o), and Rule 1300.71.4(b)(1), (b)(2) and (c).

Supporting Documentation:

- UM-89 *ER Stabilization & Post Stabilization Care (UM Access Coverage)* (August 30, 2023)
- Plan Notice to Non-Contracted Facilities[67] (December 30, 2021)
- Plan memo in response to Document Request #128 (September 25, 2024)
- 10 Plan UM Denial, Delay and Modification Files[68] (April 1, 2021 through May 31, 2023)
- 3 Plan UM Approval Files[69] (April 1, 2021 through May 31, 2023)

[66] *Clinical Criteria for Utilization Management Decision Making Policy and Procedure; Clinical Criteria for Utilization Management Decision Making Policy and Procedure State Addendum; NPA Memo.*
[67] BHIUM15_1.pdf.
[68] LFA_BHUM.
[69] Log A FP 1.

Assessment: The Plan's policies, procedures, and practices pertaining to post-stabilization services conflict with the Knox-Keene Act requirements and improperly impose potential financial risk on enrollees and providers.

A health plan contacted by a contracted or non-contracting hospital requesting authorization for post-stabilization care is required to respond within 30 minutes of receipt of the request and either approve or disapprove the request. If a plan does not authorize the requested care, it must inform the hospital the plan will arrange to promptly transfer the enrollee to another health care provider or hospital.[70] These requirements permit health plans only two options: authorize or promptly transfer and notify the hospital of the plan's option within 30 minutes. The health plan may request the hospital provide the enrollee's diagnosis and relevant information reasonably necessary to make the decision or promptly transfer,[71] but the law does not provide an exception to the 30-minute timeframe. If the health plan does not notify the hospital within 30 minutes which of the two specific options it elects, the post-stabilization care is deemed authorized, and the plan must pay for the care.[72]

The Plan's policy *ER Stabilization & Post Stabilization Care (UM Access Coverage)* states that when a contracted or non-contracted hospital initiates post-stabilization care, the hospital is responsible for contacting the Plan and "relevant clinical information needs to be provided," citing Section 1262.8. If the submitted clinical information "is not sufficient" or "does not support medical necessity" the Plan may deny inpatient level of care and notify the hospital within 30 minutes. This policy notes that "an inpatient level of care denial can be overturned later" if additional clinical information is provided and "this process may exceed the 30-minute timeframe." The *UM Access Coverage* policy further states that observation stays up to 72 hours do not require prior authorization. If the hospital requests inpatient level of care and the Plan "believes that observation status is more appropriate," then the Plan will deny the inpatient level of care and communicate the decision to the hospital within 30 minutes.

These Plan policy provisions conflict with the requirements of the Knox-Keene Act and Section 1262.8 requirements. First, it is the Plan's responsibility to request needed clinical information, and only "information reasonably necessary to make the decision or promptly transfer."[73] The Plan's policies, however, put the onus on the hospital, stating the "relevant information needs to be provided," without mentioning a request from the Plan. The Plan's policies also improperly permit the Plan to avoid the 30-minute notification requirement in which the Plan must state it either authorizes treatment or promptly transfers the enrollee. Instead, the Plan's policies permit the Plan to exceed the 30-minute limit, wait for additional clinical information to possibly overturn a denial, elect to provide Observation level of care (even if that was not the level of care requested), and take 72 hours to review medical necessity. These actions are inconsistent with Sections 1262.8(d)(1) and 1371.4(j)(1).

[70] Section 1362.8(d)(1); Section 1371.4(d) & (j)(1); Rule 1300.71.4(b)(2) & (c).
[71] Section 1262.8(b)(3).
[72] Section 1262(d)(2); Section 1371.4(j)(2)(B); Rule 1300.71.4(b)(2).
[73] Section 1262.8(b)(3)

The Department reviewed the Plan's template Notice to Non-Contracted Facilities which states "those scenarios where an observation stay needs to be converted to an inpatient stay should follow the standard Molina UM process."

During interviews, the Plan's Chief Medical Officer stated that when post-stabilization requests are received, they must decide within 30 minutes. If the Plan is not able to approve the request for an inpatient level of care, then an observation level of care is approved by default, and if observation level of care was approved, the request would follow the usual protocols for utilization management authorization.

Following interviews, the Department requested the Plan provide a narrative explanation of its post-stabilization processes.[74] In response, the Plan provided a memo stating, in summary, if clinical information submitted meets medical necessity, then an inpatient level of care is authorized, and the requesting hospital is notified within 30 minutes. If the clinical information submitted "does not meet medical necessity criteria", and the requesting provider does not agree to observation level of care, then the Plan's medical director is contacted for a final decision. If the Plan's medical director finds that medical necessity is not met, then a denial is communicated to the hospital.

File Review

The Department reviewed a random sample of 35 Utilization Management denial files. Of these 35 files, 10[75] files involved requests for acute inpatient care following Emergency Department treatment. The Department found that in all 10 files (100%), the Plan failed to respond to the requesting provider within 30 minutes with a decision to approve in-patient care or inform the facility or hospital that the Plan will arrange to promptly transfer the enrollee to another health care provider or hospital.

Case Examples

- **LFA_BHUM File #31**: On January 3, 2022, at 10:44 the Plan received notification of an acute voluntary inpatient hospitalization admission at a contracted facility for an enrollee with a diagnosis of alcohol dependence and alcohol withdrawal seizure following treatment in the Emergency Department. The staff notes indicate "extension implemented to allow time for receipt of clinical information." The medical director made the decision to deny the hospital stay of "1.3.22 through discharge" on January 5, 2022, at 09:59. The notes indicated the enrollee had been discharged from the hospital on January 4, 2022. The provider was notified of the decision on January 5, 2022, via fax. This file demonstrated that the Plan failed to provide a response to the requesting provider within 30 minutes of the request and failed to deem the inpatient care authorized. Additionally, the medical director modified the request to observation level of care instead of approving the request or transferring the enrollee.

[74] Document request #128.
[75] LFA_BHUM Files: 11, 31, 40, 41, 46, 47, 50, 53, 56, 61.

- **LFA_BHUM File #56: O**n December 21, 2022, at 21:19 the Plan received notification of an acute inpatient hospitalization admission under an involuntary hold at a contracted facility for an enrollee with a diagnoses of anorexia, schizophrenia, and psychosis following treatment in the Emergency Department. The staff notes indicate, “extension implemented to allow time for receipt of clinical information.” The medical director made the decision to deny the hospital stay of December 21, 2022, through discharge on December 23, 2022, at 13:23, and stated, “observation admission is approved.” The provider was notified of the decision by fax on December 23, 2022, at 14:21. The notes indicate the enrollee was discharged from the hospital on December 23, 2022. This file demonstrated that the Plan failed to provide a response to the requesting provider within 30 minutes of the request and failed to deem the inpatient care authorized. Additionally, the medical director modified the request from inpatient to observation level of care, rather than either approving the requested level of care or informing the hospital the Plan will arrange to promptly transfer the enrollee to another health care provider or hospital.

- **LFA_BHUM File #61:** On February 21, 2023, at 13:09 the Plan received notification of an acute inpatient hospitalization admission at a contracted facility for an enrollee with a diagnosis of alcohol dependence with withdrawal following treatment in the Emergency Department. The Plan staff notes indicated “Extension implemented to allow time for receipt of clinical information”. The Plan received clinical information faxed from the facility on February 21, 2023 at 15:15 and 2/22/2023 at 16:54. The medical director made the decision to deny the entire inpatient admission from February 20 through February 22, 2023 on February 23, 2023 at 08:13 and stated, “The hospital can bill this as outpatient or observation care. This file demonstrated that the Plan failed to provide a response to the requesting provider within 30 minutes of the request and failed to deem the inpatient care authorized. Additionally, the medical director modified the request from inpatient to observation level of care, rather than either approving the requested level of care or informing the hospital the Plan will arrange to promptly transfer the enrollee to another health care provider or hospital. The file noted this decision was overturned by a Plan medical director on appeal August 8, 2023 and the inpatient admission was approved.

Conclusion: The Plan’s policies state that a 30-minute response will be provided, but also that denials may be made, and that these denials may exceed the 30-minute timeframe. Additionally, the policies allow for modification of an inpatient admission request to observation. These processes, which were confirmed by information obtained during Plan staff interviews to be the Plan’s practices, are not consistent with the Knox Keene Act post-stabilization requirements. Furthermore, the Department’s file review demonstrated that decisions regarding requests for post-stabilization care were not communicated to the requesting provider within a 30-minute timeframe, and that modifications of these requests from in-patient care to observation care were performed. Therefore, the Department finds the Plan in violation of Sections 1371.4(d), (j)(1) and (j)(2)(B), and 1262.8(b)(3), (d)(1), (d)(2), (o), and Rule 1300.71.4(b)(1), (b)(2) and (c).

#8: <u>The Plan fails to consistently ensure appropriate discharge planning for enrollees.</u>

Statutory/Regulatory Reference(s): Sections 1367(d), 1367.03(a)(5)(F) and 1374.72(d)

Supporting Documentation:

- Plan Policy *Inpatient/Concurrent Review* (May 31, 2023)
- Plan Policy *Inpatient Utilization Review Process* (November 29, 2023)
- Plan Policy *Coordination of Care and Referral Procedure for Behavioral Health Services Policy* (May 22, 2023)
- Plan Procedure *Coordination of Care and Referral Procedure for Behavioral Health Services Policy* (May 22, 2023)
- 8 UM Denial, Delay, and Modification Files (April 1, 2021 through May 31, 2023)
- 13 UM Approval Files (April 1, 2021 through May 31, 2023)
- 3 In Depth Files (April 1, 2021 through May 31, 2023)

Assessment: The Plan is required to provide behavioral health services to its enrollees in a manner providing continuity of care and ready referral of patients to other providers when appropriate, including referrals to out-of-network providers. The Plan's *Inpatient/Concurrent Review* and *Inpatient Utilization Review Process* both describe a process for the Plan to coordinate discharge needs for its enrollees when admitted as inpatient. The Plan's *Coordination of Care and Referral Procedure for Behavioral Health Services* Policy also includes a process for the Plan to coordinate both in-network and out-of-network behavioral health services. However, file review and interviews revealed the Plan is failing to provide continuity of care or follow through on discharge planning for its enrollees.[76]

During interviews, the Plan stated discharge planning was performed by case management.

<u>File Review</u>

The Department reviewed a random sample of 35 utilization management denial files. Of these 35 files, eight[77] involved behavioral health acute inpatient hospitalizations. The Department found no evidence of active discharge planning by the Plan for the enrollees in any (100%) of these files.

The Department also reviewed a random sample of 13 Utilization Management approval files. All 13 files[78] involved situations where an enrollee was transitioning to another facility or moving to a lower level of care from acute inpatient, residential treatment center care, or intensive outpatient care and required discharge planning.

[76] Sections 1367(d); 1367.03(a)(5)(F) and 1374.72(d).
[77] LFA_BHUM Files: 11, 31, 40, 46, 50, 53, 56, 61.
[78] Log A FP 1 Files: 1, 2, 3, 4, 7, 8, 10, 14, 17, 21, 27, 37, 47.

There was no evidence of active discharge planning by the Plan for the enrollees in any (100%) of these files.

The Department also reviewed five in-depth enrollee files. Of these five files, three[79] of the files involved enrollees with discharge planning needs. There was no evidence of active discharge planning by the Plan for the enrollees in all (100%) of these files.

Case Examples

- **LFA_BHUM File #11:** The enrollee was admitted to inpatient care for anxiety and alcohol withdraw symptoms on July 8, 2021, at 16:00. The Plan was notified of the admission on July 9, 2021, at 13:00. The file states that the enrollee was discharged on July 10, 2021, at approximately 14:15.

The file indicates that the Plan denied the inpatient stay and failed to perform discharge planning for this enrollee or assist in the transition of the enrollee to a lower level of care.

- **In-Depth File #1:** An adult enrollee required treatment related to an eating disorder between the dates of March 1, 2022, and February 28, 2023. During this time, the enrollee presented to the Emergency Department twice and was admitted into a Residential Treatment Center program for eating disorders. Case Management documented information about these events but did not actively assist the enrollee in obtaining care, nor was it proactive in arranging or even becoming aware of discharge needs to prevent deterioration of the enrollee's status or to ensure continuation of care. There were multiple requests for lists of providers, but no documentation of actions by the Case Manager to contact providers to assist the enrollee. Documented conversations with Case Management showed the enrollee indicated medications had been denied or rejected. No follow-up was documented by the Case Manager to assist the enrollee or even inquire as to reasons for these denials or rejections.

The Plan's case management failed to assist the enrollee with any discharge planning and the enrollee subsequently chose to terminate coverage with the Plan on February 28, 2023.

- **In-Depth File #2:** The enrollee required treatment related to substance abuse and suicide attempts between the dates of April 24, 2021 and March 10, 2023. During this time, the enrollee had eight hospitalizations for suicide attempts and worsening symptoms over a few months starting in April 2021. There was no documentation of the Plan reaching out to the enrollee or provider to coordinate or assess post-hospitalization care or to provide case management. Notes within the file indicated that the enrollee's insurance was not accepted at a Residential Care provider that the enrollee was referred to from a hospitalization in June 2021. The enrollee was admitted to inpatient care several more times in 2021 with the last one noted in August of 2021.

[79] In-Depth Files: 1, 2, 3.

There was no active discharge planning documented in this file. The Plan failed to actively coordinate with providers or options for care. The enrollee was discharged home in June 2021 with no appointment for follow-up and no outpatient services or contact by the Plan to coordinate post-hospitalization services. With the last hospitalization noted in August 2021, the enrollee was to obtain outpatient services, including electroconvulsive treatment, and the Plan failed to coordinate post-hospitalization services.

Conclusion: The Knox-Keene Act and the Plan's policies require the Plan to provide coordination of post-hospitalization needs of enrollees through the Plan's case management system. The Department's file review demonstrated the Plan failed to ensure appropriate discharge planning or coordination of care as required by Sections 1367(d), 1367.03(a)(5)(F) and 1374.72(d). Therefore, the Department finds the Plan in violation of these requirements.

#9: 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.

Statutory/Regulatory Reference(s): Sections 1374.721(a), (b), (c), (f)(1) and (4),1367.01(h)(4), 1363.5(a), (b)(2)(4) and (5).

Supporting Documentation:

- TMS Memo (June 19, 2024)
- UM Denial and Modification Files (April 1, 2021 through May 31, 2023)

Assessment: The Plan's communications to enrollees and providers regarding decisions to deny, delay, or modify services shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the Plan's decision regarding medical necessity.[80] Any criteria or guidelines used by the Plan must be disclosed to the provider and enrollee if used to deny services and be available to the public upon request.[81]

When conducting utilization review of behavioral health care services, the Plan is required to apply the clinical criteria and guidelines set forth in the most recent versions of treatment criteria developed by the NPA for the relevant clinical specialty[82] subject to certain exceptions.[83] Medical necessity determinations must be based on

[80] Section 1367.01(h)(4).
[81] Section 1363.5(b)(4) & (5).
[82] Section 1374.721(b).
[83] A health plan shall not apply different, additional, conflicting, or more restrictive criteria than those set forth by the NPAs unless the plan uses clinical criteria that meet either of the following requirements: (1) are outside the scope of the criteria set forth by the NPAs, provided the utilization review criteria are supported by clinical principles and processes, or; (2) relate to advancements in

current generally accepted standards of behavioral health care.[84] Further, utilization review criteria is defined as any criteria, standards, protocols, or guidelines used by a plan to conduct utilization review.[85]

Health plans' utilization review policies and procedures must be filed with the Department and ensure that medical necessity decisions are consistent with criteria and guidelines that are supported by clinical principles and processes.[86]

None of the clinical guidelines or criteria developed by NPAs for the relevant behavioral health clinical specialties apply to TMS. In situations such as this, the Knox-Keene Act allows the Plan to use different clinical guidelines or criteria that are outside the scope of the criteria set forth by the NPAs as long as such criteria meet statutory requirements.[87]

The Utilization Management files reviewed by the Department demonstrated the Plan used Milliman Care Guidelines (MCG) as utilization review criteria when reviewing TMS treatment requests. The files also indicate the Plan had a practice of authorizing only half of the quantity of TMS treatment requested and in modification letters to enrollees cited to an unnamed Plan "policy" as support for that decision. However, the MCG clinical guideline does not describe recommended treatment durations or amounts, nor does it describe a practice or recommendation of authorizing half of requested TMS treatment quantity. Further, the Plan did not have a specific policy regarding authorization protocols for TMS treatment requests. Therefore, the Plan could not demonstrate that medical necessity decisions authorizing only half of the requested treatment amount were consistent with clinical criteria and guidelines that are supported by clinical principles and processes.

The Plan's practice results in the provider contacting the Plan during the enrollee's course of treatment to request authorization of the additional TMS hours, which could result in delays to care or enrollees not completing their provider's recommended TMS treatment.

In response to the Department's request for the Plan's policy or protocol that support authorizing only half of the requested TMS treatment quantity, the Plan submitted a narrative response (TMS Memo).[88] In its response the Plan stated it does not have a specific policy regarding authorization protocols for TMS treatment. The response further indicated that during the BHI review period the Plan requested approval from the Department to use a different clinical guideline for TMS developed by the Department of Defense, Veterans' Affairs (VA/DoD)[89] but that the VA/DoD TMS

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technology or types of care not covered by the NPA criteria, provided the utilization review criteria are supported by clinical principles and processes (Section 1374.721(c).)

[84] 1374.72((a)(3) and (a)(5), 1374.721(a)(f)(1)

[85] 1374.721(f)(4)

[86] Section 1367.01(b) and 1363.5(a) and (b)

[87] Section 1374.721(c)(1)

[88] Document Request # 32

[89] The guideline was reviewed as part of the Plan's SB 855 1374.721 compliance filing that was approved by the Department on January 25, 2024, efiling # 20211085. It is unclear when the Plan

clinical guideline does not "describe variations in treatment based upon the individual treating clinicians judgement," or state how long a course of treatment should be. The TMS Memo further stated TMS is a "treatment that is indicated for three to five months," and that "Molina authorizes half of that expected time frame and then checks in to see if the member is still in treatment."

The Department reviewed a random sample of 35 Utilization Management denial files. Of these 35 files, four[90] (11%) involved the Plan authorizing half of the requested treatment hours.

Interviews

During interviews, the Department asked the Plan to explain what policy was used to deny half of a total course of requested TMS treatment. The Medical Director for Behavioral Health indicated there was no specific policy. He clarified that a treatment such as TMS may go on for months and the intent was to get a quality check after a portion of the sessions and that it was clinical judgement to approve a portion initially. The Plan confirmed it does not have a written guideline for its denial of half of requested TMS treatment amounts, and it would not be able to provide such a guideline to the public upon request.

Case Examples

- **LFA_BHUM File #15:** On August 17, 2021, a request for six months of TMS treatment was submitted. The letter to the enrollee cites criteria used for the decision as "MCG Transcranial Magnetic Stimulation (B-801-T)" and states:

  > Molina cannot okay the request for treatment for your brain with strong magnets (TMS) exactly as asked for but will okay treatment. A Molina Healthcare doctor looked at this. The doctor used standard rules. The request does not meet the rules. We were told you feel very sad. Your doctor wants to do a special treatment on your brain with strong magnets. The facts sent to us show the treatment is appropriate. However, policy okays only half the total course at one time. If your doctor feels you are responding, they can request the balance of the sessions then. That is why Molina cannot cover this treatment exactly as asked for but will okay treatment.

- **LFA_BHUM File #36:** On March 16, 2022, a request for 36 sessions of TMS treatment was submitted. The letter to the enrollee cites the criteria used as "MCG 25th ed. B08010T Transcranial Magnetic Stimulation" and fails to include the clinical reasons for the Plan's decision regarding medical necessity. The letter states:

started using the VA/DoD TMS clinical guideline, but the files reviewed as part of this BHI all involved the use of the MCG guideline.

[90] LFA_BHUM Files:15, 32, 36, 57,

> Molina cannot okay special brain treatment (TMS) exactly as asked for but will okay the treatment. A Molina Healthcare doctor looked at this. The doctor used standard rules. It does not meet the rules. We were told you have depression. Your doctor wants to do a special treatment on your brain with strong magnets. The facts sent to us showed this treatment does meet the rules. However, Molina policy will only okay half of the treatment at first to see if you tolerate it well and if it works. Your doctor can request more sessions when they are needed.

- **LFA BHUM File #57:** On January 9, 2023, a request for 36 sessions of TMS treatment was submitted. The letter to the enrollee cites the criteria used as "MCG Transcranial Magnetic Stimulation (B-801-T)" and states:

> Molina cannot okay the request for treatment for your brain with strong magnets (TMS) exactly as asked for but will okay treatment. A Molina Healthcare doctor looked at this. The doctor used standard rules. The request does not meet the rules. We were told you feel sad. Your doctor wants to do a special treatment on your brain with strong magnets. The facts show this is appropriate. However, the request is for the entire course of treatment. Guidelines suggest half the expected sessions be okayed at first. If more are needed, then your doctor can request them at that time.

In the above file examples, with respect to the Plan's decision to authorize only half of the requested TMS course of treatment, the letters fail to include a clear and concise explanation of the reasons for that decision, a description of the criteria or guidelines used to support that decision, and the clinical reasons for the Plan's decision regarding medical necessity. Further, the letter does not identify the specific policy that supports the modification. MCG guidelines do not recommend a specific number of treatments and the Plan does not have a written policy to "okay half of treatment at first."

Conclusion: During the BHI review period the Plan did not utilize clinical criteria or guidelines that are supported by clinical principles and processes when making decisions to authorize half of the requested amount of TMS treatments.[91] Further, the Plan's modification letters to enrollees referenced an unnamed "policy" that supports its modification decision that failed to exist. This practice is not consistent with any of the Plan's Department approved clinical criteria or guidelines for use during the BHI review period. Further, the letters fail to include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used to support authorizing only half of the requested treatment amount, and the clinical reasons for the Plan's decision regarding medical necessity. Therefore, the Department finds the Plan to be in violation of Sections 1367.01(h)(4) and 1363.5(b)(2)(4) and (5).

[91] As noted in Footnote # 99, the Plan did not receive approval to use the VA/DoD TMS clinical policy until after the BHI review period.

QUALITY ASSURANCE

#10: The Plan does not adequately oversee its behavioral health triage and crisis line delegate.

Statutory/Regulatory Reference(s): Section 1367.03(a)(8) and (e) and Rules 1300.67.2.2(c)(8), (b)(19) and (b)(20) and 1300.70(b)(2)(B)

Supporting Documentation:

- Plan Oversight and Monitoring Policies and Procedures (September 20, 2022)
- Plan Policy *Behavioral Health Crisis Protocol Policy for Clinical and Non-Clinical Staff* (Medi-Cal & Marketplace) (January 6, 2021)
- Administrative Services Agreement with CareNet Statement of Work (SOW) (May 1, 2020)
- Carenet Call Handling Procedure (undated)
- Protocol Services Crisis and Access Specialist Policies and Procedures (October 29, 2021)
- Protocol Services Call Screening and Call Triage (March 21, 2017)
- Plan Behavioral Health Crisis Call Follow Up QRG (undated)
- Plan Policy *Delegation Oversight Program* (May 3, 2024)
- Plan Procedure *Delegation Oversight Program* (May 3, 2024)
- Plan 2024 Behavioral Health Crisis Line Audit Tool (undated)
- Plan Behavioral Health Crisis line Dashboard in response to Document Request #91, 94, 95, 119

Assessment: The Plan is required to provide 24 hours per day, 7 days per week, triage or screening services by phone and to ensure that triage and screening services are appropriate and timely.[92] If a health plan delegates these functions, then the Plan is required to provide oversight of its delegate to ensure the required functions are being adequately performed.[93]

Delegate Arrangements

During the review period, the Plan had an administrative services agreement[94] with a vendor, Carenet, to provide the Plan with call center operations, triage and screening,

[92] Triage or screening is the assessment of an enrollee'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 an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care. (1367.03(e)(5); Rule 1300.67.2.2(b)(19).) Plans must ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening wait time does not exceed 30 minutes. (1367.03(a)(8)(A); Rule 1300.67.2.2(c)(8).) Triage or screening wait time is the waiting time to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care. (1367.03 (e)(6); Rule 1300.67.2.2(b)(20.)

[93] Section 1367.03(a)(8); Rules 1300.70(b)(2)(B).

[94] eFiling #20223402

and nurse advice line services.[95] Carenet's *Call Handling Procedure*[96] specifies that if a Plan member calls with a behavioral health related issue, Carenet will transfer the caller to ProtoCall, a downstream vendor who provides behavioral health triage, screening and crisis intervention services by phone for Plan members.

Policies and Procedures

The Plan's *Oversight and Monitoring Policies and Procedures* and *Delegation Oversight Program*[97] policies describe its oversight functions of Carenet. It states that the Plan's Delegation Oversight Committee conducts ongoing and continuous oversight of Carenet to ensure compliance with contractual requirements, including monitoring and auditing activities of Carenet on a routine and focused basis.

The Plan's *Behavioral Health Crisis Protocol Policy for Clinical and Non-Clinical Staff* (Medi-Cal & Marketplace) establishes:

> "guidelines for clinical and non-clinical staff. . . to provide assessment, coordination, and referrals for members with behavioral health crises to ensure timely, emergent, and urgent access to appropriate providers", and "…guidelines for identification of when additional assistance or crisis services/EMS must be contacted to provide further assistance to members with behavioral health crises."

The procedure does not describe how the Plan oversees the operation of this crisis line.

Interviews

During interviews, Plan staff stated they contracted with a third-party, Carenet, for behavioral health triage, screening and crisis line services and referenced daily reports that were obtained from the delegate listing the calls that were received in the prior 24 hours.

In response to the Department's request[98] for a copy of the contract with Carenet, the Plan provided a Statement of Work (SOW) for behavioral health triage and screening and crisis line services which describes the call summary report. The SOW specifically provides that the delegate is to provide call metrics, triage reports and 100% recording of voice calls.[99]

The Department also asked the Plan for a copy of policies and procedures, training materials, job aids, triage protocols and scripts used by the behavioral health triage, screening and crisis line staff. The Plan provided documents[100] stating the goal is to

[95] Document Request # 90
[96] Document Request # 91
[97] eFiling #20223402
[98] Document Request #93.
[99] SOW, Sections 6.1.16, 6.8 and 8.1.
[100] Document Request #91.

follow up with enrolled members within one to three business days from the date that the call log is populated.

In response to the Department's request[101] for the Plan's policies and procedures for monitoring the quality of behavioral health triage, screening and crisis line calls, including who is responsible for listening to calls and any required follow-up if issues are identified, the Plan provided its *Delegation Oversight Program* policy which states in general how the Plan monitors and evaluates the performance and compliance of third-party entities for compliance with all regulatory and contractual requirements. This policy describes a joint operations committee that is supposed to monitor and evaluate the performance and compliance of delegated entities, but nothing specific to behavioral health triage, screening and crisis line services. Furthermore, the Plan did not provide any meeting minutes from the joint operations committee demonstrating oversight of the behavioral health triage, screening and crisis line.

Conclusion: The Plan is required to provide or arrange for the provision, 24 hours per day, 7 days per week, of appropriate and timely behavioral health triage and screening services via telephone for its enrollees.[102] The Plan has oversight policies of third-party delegates, and a policy specific to Carenet's delegated behavioral health triage, screening and crisis line functions. Although Carenet is required by contract to submit reports to the Plan, there is no evidence that the Plan is reviewing the reports or monitoring its delegate for triage wait times or ensuring that Carenet non-clinical and clinical personnel are appropriately screening and referring enrollees. Therefore, the Department finds the Plan in violation of Rule 1300.70(b)(2)(B).

#11: <u>The Plan fails to monitor and take effective action to correct identified timely access issues.</u>

Statutory/Regulatory Reference(s): Section 1367.03(a)(1) and Rule 1300.67.2.2(c)(1), 1300.70(a)(1), (3) and (b)(1)(B)

Supporting Documentation:

- Plan *Timely Access to Care NSP-9.01* (April 21, 2023)
- Plan *Network Adequacy, Availability, and Accessibility NSP 14.01*
- Plan *BH Provider CAPs_Final_08.20.2024*
- Plan *Measurement Year 2021 Provider Appointment Availability Survey Executive Summary*
- Plan *Measurement Year 2022 Provider Appointment Availability Survey Results*
- 10 Corrective Action Plans (April 1, 2021 – May 31, 2023)

Assessment: The Plan is required to establish and maintain quality assurance monitoring systems and processes sufficient to ensure services are provided in a manner consistent with good professional practice and in compliance with applicable timely access standards.[103] The Plan's quality assurance program is specifically

[101] Document Request #95.
[102] Section 1367.03(a)(8) and (e); (Rule 1300.67.2.2(b)(19)(c)(8)).
[103] Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1)

required to address accessibility and availability of care.[104] When accessibility and availability issues are identified by the Plan's quality assurance program, the Plan is required to take effective corrective action to improve access to care and follow-up where indicated.[105]

Plan Documents

The Plan's *Timely Access to Care NSP- 09.01* policy and *Network Adequacy, Availability, and Accessibility NSP 14.01* policies outline the Plan's timely access standards, including required behavioral health provider to enrollee ratios, time and distance standards, and appointment availability standards for behavioral health providers. The Plan's *Network Adequacy, Availability, and Accessibility NSP 14* policy describes the Plan's process for monitoring to ensure the Plan meets these standards. The purpose of these policies is to ensure that all medically necessary covered services are available and accessible to all enrollees for each of the Plan's lines of business.

The Plan's *Timely Access to Care NSP- 09.01* policy includes appointment time frames that meet the requirements of Section 1367.03(a)(5). A chart on page 10 of the policy identifies the benchmark goal for meeting each type of appointment timeframe. The goal for behavioral health appointment wait times is 50-80%, which is lower than the goal for Primary Care Physician appointment wait times of 85-90%. The policy does not include a rationale for each benchmark goal.[106]

The Plan's *Timely Access to Care NSP- 09.01* policy states that providers identified as non-compliant with the timely access standards are "investigated and corrective action is implemented as appropriate." This policy states the Plan will send a written notice of a corrective action plan (CAP) to a non-compliant provider; the notice identifies the timeliness standards the provider failed to meet. The policy states the CAP notification will include a description of the identified deficiencies, rationale for the corrective action, and the name and contact info for the Plan staff authorizing the CAP. Lastly, the policy states practitioners and provider offices that failed to meet any of the timely access standards during the evaluation or measurement year will be automatically added onto subsequent year's Provider Appointment Availability Survey (PAAS) population.

The results of the Plan's monitoring of its providers for timely access standards indicate that many of the Plan's providers are not meeting timely access. For example, the Plan's Measurement Year (MY) 2022 PAAS results demonstrate that none of the

[104] Rule 1300.70(a)(3)
[105] Rule 1300.70(a)(1) & (b)(1)(B)
[106] In response to document request #51 for the Plan's most up-to-date version of Policy NSP 09.01 with the Plan's current goal/benchmark for Behavioral Health Appointment Access Standards in the chart on page 10, the Plan submitted Policy NC 09.01 Timely Access to Care Procedure (effective date April 21, 2023). This is the same policy with the same effective date as policy NC 09.01 that was submitted earlier in the BHI. However, the version submitted in response to the document request is redlined with updates to the benchmark goals for behavioral health follow-up appointments. A comment is included that states, "The Behavioral Health Routine Follow-up percentages were changed from 50% and 60% to 80% in response to the Behavioral Health audit. This was redlined on 09/04/2024."

psychiatrists surveyed met timely access appointment standards as outlined in the Plan's policies, Section 1367.03(a)(5) and Rule 1300.67.2.2(c). Additionally, only 48% of the non-physician mental health providers (NMHP) surveyed had appointments available within the timely access standards. The Plan's MY 2021 PAAS[107] survey results show the percentage of psychiatrists with appointments within the timely access standards was 69% and 59% for NPMH providers. Therefore, compliance with the timely access standards by Plan providers was worse in MY 2022 than in the prior year.

The Department reviewed examples of CAPs which the Plan sent to its providers in response to their failure to meet provider appointment availability standards in the Plan's timely access surveys. These CAPs showed the Plan notified providers if their practice did not meet the provider appointment availability standards in the telephonic access survey for the relevant measurement year and included a CAP template for the non-compliant provider to complete and return to the Plan within 30 calendar days. The CAP templates included a table with the following four columns: "Description of Deficiency," "Corrective Action Plan," "CAP Timeline," and "Status."[108] The provider completes the "Corrective Action Plan" and "CAP Timeline" columns and the Plan is supposed to complete the "Description of Deficiency" and "Status," columns. In all CAP examples reviewed by the Department wherein the provider completed its required columns and returned the CAP to the Plan, the "Status" columns for the Plan to complete were blank.

During interviews, the Plan's Assistant Vice President of Government Contracts explained the goal for meeting behavioral health appointment standards had recently been updated to align with the goal for primary care physician appointments. The Assistant Vice President also reported that CAPs are issued for individual providers 100% of the time if they are not meeting timely access standards. They also stated if overall internal Plan benchmarks are not met, it is discussed and analyzed at the Access and Availability committee meetings to determine what measures can be put in place to improve compliance. The Assistant Vice President also explained that CAPs were issued for all providers who did not meet accessibility requirements in the MY 2021 and MY 2022 PAAS surveys.

The Department subsequently requested evidence that the Plan implemented and followed up on CAPs for each provider in the MY 2022 PAAS survey who did not meet appointment access standards.[109] In response, the Plan submitted a spreadsheet of non-compliant providers that were issued CAPs. The spreadsheet contained a column titled "CAP Activities" that stated "CAPs activities are ongoing" for each provider. There were three subsequent columns titled "1st follow up attempt," "2nd follow up attempt," and "3rd follow up attempt." Despite having three separate columns for the Plan to document follow-up attempts, every entry for every CAP is documented as "N/A."

[107] Plan Measurement Year 2021 Provider Appointment Availability Survey Executive Summary
[108] The "Status" column instructions state: "Enter CAP Status & Date of Status Update. *To be completed by Health Plan Staff only.*
[109] Document request # 52.

The Plan's failure to demonstrate through interviews and Plan documents that it monitors CAPs to ensure they were fully implemented by providers and that corrective actions were effective is inconsistent with the requirement to continuously review the quality of care provided and take effective corrective action to resolve identified accessibility and availability issues, as set forth in Rule 1300.70(b)(1)(B).

Conclusion: The Plan's PAAS survey results indicated multiple providers did not meet timely access standards and that corrective action was required. The Plan's policies and procedures state the Plan will promptly investigate and implement CAPs to providers that are non-compliant with the timely access standards. Despite the Plan submitting CAP examples and the Department asking the Plan for evidence that it is monitoring and taking effective action to correct identified provider timely access issues, the Plan failed to produce any evidence that it is monitoring or following up on CAPs issued to non-compliant providers. Therefore, the Department finds the Plan in violation of Rule 1300.70(a)(1) and 1300.70(b)(1)(B).

#12: <u>The Plan fails to ensure that credentialing applications for behavioral health providers are confirmed, assessed, and verified as required.</u>

Statutory/Regulatory Reference(s): Section 1374.197(a)

Supporting Documentation:

- Plan CR01- *Credentialing and Recredentialing Practitioners* Procedure (May 6, 2024)
- Plan CR01- *Credentialing and Recredentialing Practitioners* California State Addendum (June 19, 2024)
- Plan CR02- *Assessment of Organizational Providers* California State Addendum (June 19, 2024)
- Plan CR02- *Assessment and Re-assessment of Organizational Providers (May 6, 2024)*
- Plan BHI_UM_Network File
- Plan memo dated June 21, 2023 in response to Document Request #37

Assessment: The Plan is required to assess and verify the qualifications of a behavioral health care provider within 60 days after receipt by the Plan's credentialing department of a completed provider credentialing application. Upon receipt of a credentialing application, the Plan is required to notify the provider within seven business days that the application has been received and indicate whether the application is complete or missing information.[110]

The Plan's *Credentialing and Recredentialing Practitioners* California State Addendum and *Assessment of Organizational Providers* State Addendum both include the statutory 60-day and seven-day timelines for processing credentialing applications.

The Department requested a report[111] with specific data elements for all credentialing applications for behavioral health providers received by the Plan on and after January

[110] Section 1374.197(a).
[111] BHI_UM23_Network File and hereinafter referred to as "Credentialing Report."

1, 2023. The Credentialing Report included a column titled "Applicant Notification," which had numerous blank fields with no dates. The Department requested the Plan provide an explanation for this missing data[112] and the Plan's written response stated the blank dates were for applications that were complete upon receipt. The Plan's written response further stated if the Plan received what it believed to be a complete application it did not send a written notice to the applicant acknowledging receipt and that the application is complete within seven business days of receipt.

The Department's review of the Plan's Credentialing Report revealed instances[113] of the credentialing process taking over 60 days to assess and verify the qualifications of a behavioral health care provider after the application was deemed complete. Additionally, the date the application was deemed complete on recredentialed applicants was not included on the report and the timeframe for completion could not be determined.

Conclusion: The Plan is required to notify providers within seven business days of receipt of a credentialing application to verify receipt and inform the provider whether the application is complete.[114] The Plan acknowledged[115] it only notified behavioral health providers if the provider's credentialling application was incomplete and/or missing information and did not notify providers that submitted completed applications within the required seven business days. Additionally, the credentialing report provided by the Plan shows instances of the credentialing process exceeding 60 days after receipt of a completed application by the Plan's credentialing department. Therefore, the Department finds the Plan in violation of Section 1374.197(a).

#13: <u>The Plan does not adequately monitor for trends in over and under-utilization of behavioral health care services.</u>

Statutory/Regulatory Reference(s): Section 1367.01(j) and Rule 1300.70(a)(3) and (c)

Supporting Documentation:

- Over and Under Utilizations Report (November 5, 2023)
- *Monitoring to Ensure Appropriate Utilization Policy CA-HCS-362* (November 29, 2023)
- *Monitoring to Ensure Appropriate Utilization Procedure CA-HCS-362.01* (November 29, 2023)
- *Under and Over Utilization Memo* (June 4, 2024)
- Over-utilization and Under-utilization Q1 2023 Report (February 15, 2023)
- Over-utilization and Under-utilization Q2 2023 Report (May 31, 2023)
- Over-utilization and Under-utilization Q3 2023 Report (August 31, 2023)
- Over-utilization and Under-utilization Q4 2023 Report (November 29, 2023)

[112] Plan Response to Request #37.
[113] Providers 302 and 319 are examples.
[114] Section 1374.197(a).
[115] Document Request Response #37 (June 23, 2023)

Assessment: Health plans are required to establish as part of their quality assurance programs the assessment of trends and implementation of actions to correct identified problems.[116] Health plans' quality assurance programs are required to have procedures for continuously monitoring whether the provision and utilization of services meet professionally recognized standards of practice.[117]

A health plan's quality assurance program is the structural framework it uses to monitor, evaluate, and improve the health care delivered to its enrollees. The program directly impacts quality of care. Therefore, if a health plan is not collecting specific information about the utilization of behavioral health care services, then the health plan cannot know whether utilization of such services meets professionally recognized standards of practice and that quality of care is being provided. Health plans' quality assurance programs are required to collect and analyze over-utilization and under-utilization of behavioral health care services.[118] Monitoring general utilization data is not enough; health plans' quality assurance programs must identify trends and implement corrective action to correct identified problems in utilization of all services.[119]

Plan Policies and Procedures

The Plan's *Under and Over Utilization Memo*[120] stated that the Plan trains all utilization management review staff on policies and procedures, including policies for over-and under-utilization. The memo further states that over and under-utilization is monitored, discussed and presented quarterly to the Healthcare Services Committee (HCS Committee), and clinical leadership send the results of such discussions to UM review staff to "facilitate monitoring over/under utilization."

The Plan's *Monitoring to Ensure Appropriate Utilization* policy and *Monitoring to Ensure Appropriate Utilization* procedure[121] both state that its purpose is to detect and correct potential over and under-utilization of services for medical and behavioral health care services. The policy and procedure state regular monitoring of data for over and under-utilization is the responsibility of the HCS Committee. The HCS Committee reviews the utilization monitoring reports at least annually, which may include data from major areas such as: (1) inpatient admissions and days of care; (2) outpatient visits, including emergency department visits; (3) selected surgical procedures or diagnostic tests; and (4) possible under-utilization of specialist services and preventative care services. The policy and procedure further describe how the

[116] Section 1367.01(j)
[117] Rule 1300.70(a)(3) and (c)
[118] Examples of over utilization would be over prescribing medication, ordering unnecessary procedures or providing non-medically necessary services, an excessive reliance on telehealth for patients who would benefit more from in person care or for conditions where telehealth is not a clinically sound option, etc. Examples of under-utilization of services could be under prescribing medication despite their evidence based proven effectiveness to treat certain conditions, failure to refer to specialty behavioral health providers, denials of medically necessary behavioral health care services, etc.
[119] Section 1367.01(j) and Rule 1300.70(a)(3).
[120] BHIUM13_Memo20240604.pdf
[121] BHIUM13_CA-HCS-362 Monitoring to Ensure Appropriate Utilization Policy and BHIUM13_CA-HCS-362 Monitoring to Ensure Appropriate Utilization Procedure

Plan's analysis of utilization of services will identify services that exceed over utilization or fall short of under-utilization thresholds.

The policy and procedure explain that HCS Committee staff will design interventions based on the complexity and scope of the investigation. HCS Committee staff then measure intervention parameters and outcomes periodically to assess progress and impact.

Plan Reports

The Department reviewed the Plan's submission of reports[122] pertaining to the monitoring of provider referrals and specialist care involving behavioral health services, and over and under-utilization of behavioral health services[123].

The Department found these reports failed to include sufficient fields to enable the Plan to evaluate the provision of behavioral health services by diagnosis and service codes. One such report was an Over and Under Utilization Report which only identified Mental Health office visits by provider group without any additional detail.[124] Other services in the Over and Under Utilizations Report under the category "General" identified utilization of ER visits, Office Visits, and Inpatient admissions per 1000 enrollees, as well as a category of "Urgent Care" which included office visits per 1000 enrollees.

The Plan also submitted PowerPoint slideshows titled "Over-utilization and Under-utilization Report" for the first, second, third and fourth quarters of 2023.[125] According to the first slide, these reports appeared to have been presented by the Plan's medical director to the HCS Committee. The reports included slides for general office visits by provider groups with more than 1000 members, mental health office visits by provider groups with more than 1000 members, ER visits, inpatient admissions, and an "Analysis" slide. The "Analysis" slide for the Over-Utilization and Under-Utilization Q2 2023 Report notes that, "Q1 2023 office visits are lower than Q4 2022 across all providers. It is unclear what is the driver for this reduction. There also appears to be a continued encounter data log in this report." The Q3 and Q4 reports also documented a decrease in office visits for both PCPs and mental health office visits each quarter, but the "Analysis" slide simply concludes that data for office visits are "steady relative to 2022."

The Plan also provided Behavioral Health Treatment (BHT) PowerPoint reports for the second and third quarters of 2023 that were presented to the HCS Committee.[126] These reports were limited to data pertaining to Qualified Autism Service Providers and included a level of detail not present in the other reports. The BHT reports discussed trainings of Board Certified Behavior Analyst (BCBA) providers, the number of Plan members with an open authorization for BHT, the number of BHT providers by

[122] Plan response to Pre-Onsite Request # 21.
[123] BHIPRP4_1.xlsx.
[124] Id. This Over and Under Utilization Report covered the BHI review period of April 1, 2021 through May 31, 2023.
[125] Plan response to Pre-Onsite Request # 21.
[126] Plan response to Pre-Onsite Request # 21.

county, and next steps for the Plan to take to ensure appropriate utilization of the Plan's BHT benefit.

With the exception of the BHT reports, the utility of the Plan's over and under-utilization reports are limited because the Plan did not track usage of services and hospitalization or re-admit rates by diagnosis or service code. The general nature of these reports will make it difficult to identify specialty behavioral health care services[127] that are being under-utilized. For example, the report tracks the number of mental health office visits by provider groups, but does not capture what specific mental health services enrollees are accessing (i.e., drug addiction, anxiety, depression, etc.).

If the Plan cannot accurately identify trends regarding behavioral health care services because the Plan does not know why enrollees are accessing behavioral health services and what specific treatment they are receiving, and conversely, why enrollees are not accessing services, then the Plan cannot identify trends in over and under-utilization and implement actions to correct identified problems.

As a result, the Plan may not have an accurate picture why enrollees are utilizing some services more than others and therefore may be missing an opportunity to conduct a root cause analysis and make necessary changes to address over and under-utilized services. The Plan did not provide any HSC Committee notes to indicate whether over and under-utilization issues were identified, reported and/or acted upon. In fact, the Over-Utilization and Under-Utilization PowerPoint Reports for Q1, Q2, Q3 and Q4 of 2023 all document a decrease in mental health office visits, but no indication any action was taken to correct the decrease.

The Plan's current practice of monitoring utilization of only certain services, or broad categories of services, per 1000 enrollees fails to capture whether the utilization of services meets professionally recognized standards of practice. Furthermore, the Plan appears to be conducting a surface-level analysis of the utilization data it does collect and provided no evidence of any corrective action taken to correct identified issues.

Conclusion: The Plan's quality assurance system is required to assess trends and implement actions to correct identified problems and to continuously monitor utilization of services to ensure they meet professional recognized standards of practice.[128] Utilization that fails to meet professionally recognized standards may result in over- and under-utilization of behavioral health care services. The Plan's policy and procedure describe in general how the Plan tracks the over-and under-utilization of categories of services and how any trends are to be reported to the HCS Committee for further interventions. However, the reports provided by the Plan as part of this BHI lacked the detail required to accurately assess and report whether behavioral health care services were being over or under-utilized. Furthermore, the Plan did not produce any evidence that any interventions or corrective action was taken during the review period to address or remedy any over or under-utilized behavioral health care services

[127] "Specialty" behavioral health care services would include services provided by psychiatrists, psychologists or other doctoral level behavioral health care providers.
[128] Section 1367.01(j) & Rule 1300.70(a)(3)

to ensure utilization of behavioral health care services met professionally recognized standards of practice. Therefore, the Department finds the Plan in violation of Section 1367.01(j) and Rule 1300.70(a)(3) and (c).

GRIEVANCE AND APPEALS

#14: **The Plan fails to consistently adequately consider all issues within enrollee grievances and provide rectification when appropriate.**

Statutory/Regulatory Reference(s): Section 1368(a)(1) and Rule 1300.68(a)(4)

Supporting Documentation:

- Plan *Member Grievance Process (Marketplace)* (May 31, 2022)
- Plan *Member Grievance Process Defining and Identifying Grievances MP,-* Document Request 76 (September 10, 2024)
- Plan iServe Request for POD Data Inaccuracy Correction*,* Document Request #76 (September 10, 2024)
- 25 Plan Access and Availability Grievance Files (April 1, 2021, through May 31, 2023)
- Plan report of iServe Tickets submitted by GA specialists for Provider Directory Inaccuracies for files listed in Log F, Document Request 88 (September 10, 2024)
- Plan report of iServe Tickets submitted for Provider Directory Inaccuracies submitted by GA specialists for CA Marketplace enrollment for survey period, Document Request 89 (September 10, 2024)
- Plan Quarterly Grievance Report Q1 2022 (April 20, 2022)

Assessment: The Plan's grievance system is required to provide "reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate."[129] A grievance is considered resolved when the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.[130]

Policies and Procedures

The Plan's *Member Grievance Process (Marketplace)* and *Member Grievance Process Defining and Identifying Grievances* describes the Plan's grievance process in general[131] and identifies "Provider Directory Inaccuracies" as a standard grievance that is subject to grievance review. As described in Violation #1 above, the Plan's

[129] Section 1368(a)(1).
[130] Rule 1300.68(a)(4).
[131] In the Member Grievance Process Defining and Identifying Grievances process document, the Plan defines a grievance as "an expression of dissatisfaction by a member or an authorized member representative regarding an aspect of the health plan"; the Plan provides six general categories of "aspects related to Health Plan" including Health Plan Operations, Molina Staff, Provider Network, Health Plan Delegated Vendor, Concerns about Providers, and Billing.

iServe Request for POD Data Inaccuracy Correction job aide requires the Plan's CSRs to submit provider directory discrepancy tickets when a provider directory inaccuracy is reported. The Plan's grievance and appeals team is also required to independently review the CSR's case notes for matters escalated by the CSRs to determine if a provider directory inaccuracy was raised by the enrollee. If the grievance and appeals staff find that a potential provider directory inaccuracy was raised and the CSR did not document submitting an iServe ticket, then the grievance and appeals staff will submit the ticket.

File Review

The Department reviewed a random sample of 25[132] standard grievance files categorized as Access and Availability issues related to behavioral health. In 15[133] out of 25 files (60%) enrollees reported an issue with the provider directory. However, none of these files included a note to indicate the grievance and appeals specialist addressed the inaccurate provider directory concern raised by the enrollees and followed the Plan's prescribed process of submitting an iServe ticket to address the provider directory inaccuracy.

Interviews

During interviews, in response to the Department's request to describe the Plan's process when an enrollee reports a directory inaccuracy, the Plan's Vice President of Appeals and Grievances reported that CSRs were required to file an iServe ticket when informed of a potential provider directory inaccuracy and document the iServe ticket number in the case notes.

According to the Vice President, the case notes remain visible as the file moves through the grievance system. The Vice President reported that if the CSR fails to submit an iServe ticket, the grievance team was responsible for investigating and submitting the report of the potential provider directory inaccuracy through the same iServe ticket process and noting the submission in the case file.

The Department informed Plan staff that its review of the Plan's call inquiry and grievance files failed to find documentation of the submission of an iServe ticket in any of the files that contained a reported directory inaccuracy. The Department requested the Plan to identify where the iService ticket was documented in the case files. The Vice President reported the documentation would be found in the notes of the grievance file.

As described in Violation # 1 above, the Plan acknowledged that no iServe tickets were submitted for any of the Access and Availability grievance files reviewed by the Department.

The Department requested a report of all iServe tickets submitted by GA specialists for reported provider directory inaccuracies for the entire Marketplace membership for

[132] LFF_AA Files: 1-25.
[133] LFF_AA Files: 1-6, 8, 10, 15, 17, 18, 21-23, 25.

the review period. The Plan provided a spreadsheet showing it identified a total of 25 potential directory inaccuracies reports out of 53 Access and Availability grievances related to enrollee reported provider directory inaccuracies over the two-year review period.

To better understand the Plan's overall behavioral health grievance trends, the Department reviewed the Plan's Behavioral Health Grievances and Appeals Log[134] for the review period and found 82 of the 101 (81%) entries were categorized as Access and Availability grievances. Of the 82 Access and Availability grievances, a disproportionate amount, 53 grievances (65%) included reports of provider directory inaccuracies.

Conclusion: Information obtained during interviews and from Plan's policies and job aides showed that identifying and rectifying provider directory inaccuracies is the responsibility of the grievance team as part of the grievance resolution process. However, the Department's review of the Plan's grievance case files and reports documenting submission of iServe tickets demonstrated the Plan's grievance team failed to identify, investigate and rectify complaints of potential provider directory inaccuracies, therefore failing to provide adequate consideration and resolution of enrollee grievances as required by Section 1368(a)(1) and Rule 1300.68(a)(4). Therefore, the Department finds the Plan in violation of these requirements.

#15: **The Plan's customer service staff fail to consistently identify enrollee expressions of dissatisfaction as grievances.**

Statutory/Regulatory Reference(s): Section 1368(a)(1) and Rule 1300.68(a)(1)

Supporting Documentation:

- Plan *Member Grievance Process* (May 31, 2022)
- Plan *Member Grievance Process Defining and Identifying Grievances MP* (Undated)
- Plan *SQA Contact Center Service Quality Guidelines April 1-May 2nd, 2021* (May 12, 2020)
- Plan *SQA Contact Center Service Quality Guidelines May 3, 2021- June 30, 2022* (September 30, 2021)
- Plan *SQA Contact Center Service Quality Guidelines July, 2022 – June 30, 2023* (September 28, 2022)
- Plan CA MP SQA Scores Report 2021-2023 (Undated)
- 18 Plan Behavioral Health Repeat Caller Files (April 1, 2021, through May 31, 2023)
- 56 Plan Behavioral Health Provider Network Call Inquiry Files (April 1, 2021, through May 31, 2023)

Assessment: The Plan is required to identify written or oral expressions of dissatisfaction from enrollees as grievances and to ensure adequate consideration

[134] Log F.

and rectification when appropriate.[135] In addition, when a health plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[136]

Policies and Procedures

The Plan's *Member Grievance Process* policy describes the Plan's process for the identification and resolution of its enrollee's appeals and grievances. The Plan's *Member Grievance Process Defining and Identifying Grievances MP* job aide describes the Plan's process for identifying grievance calls received by its CSRs for Marketplace enrollees, which states in summary that anytime a member expresses dissatisfaction with any aspect of the health plan, the information must be escalated to a grievance. The Plan's *SQA Contact Center Service Quality Guidelines*[137] describes how the Plan's call center staff are formally evaluated for quality, and one of the categories measured is whether the Plan staff correctly identified a grievance.

However, the Plan's CA MP SQA Scores Report 2021-2023 indicated that its call center staff incorrectly handled and closed calls in which the caller may have had an unresolved issue or an expression of dissatisfaction.

Interviews

During interviews, the Plan's Director of Member Services reported that its staff are "fully trained" in identifying key words and identifying expressions of dissatisfaction. When the Department asked whether the Plan listens to behavioral health calls separately to identify possible missed expressions of dissatisfaction, the Director stated they do not isolate behavioral health calls for review and that this has not been a trending area during their time employed at the Plan.

File Review

The Department reviewed a random sample of 18 behavioral health repeat caller files and associated audio recordings and found that in three of 18 calls[138] (17%) the CSR staff member failed to recognize an expression of dissatisfaction and file a grievance. The Department also reviewed 53 call inquiry files in which the enrollee was calling for information about finding a provider. In 33 of the files where audio recordings were not available, the case notes indicated that in three[139] of 33 (9%) of these files, the call should have been handled as a grievance. Of the 20 files[140] that did have audio recordings to supplement the case notes, the Department found in seven[141] of 20 (35%) files, the call should have been handled as a grievance.

[135] Section 1368(a)(1); Rule 1300.68(a)(1).
[136] Rule 1300.68(a)(1).
[137] SQA Contact Center Service Quality Guidelines April 1-May 2nd, 2021 (May 12, 2020); SQA Contact Center Service Quality Guidelines May 3, 2021- June 30, 2022 (September 30, 2021); SQA Contact Center Service Quality Guidelines July 2022 – June 30, 2023 (September 28, 2022).
[138] Repeat Caller Inquiry LFC_18 Files: 12, 14, 16.
[139] LFC_PNI Files: 13, 16, 17.
[140] LFC_PNI Files: 37-56.
[141] LFC_PNI Files: 37, 42-44, 48, 51, 56.

Case Examples

- **LFC_18 File #12:** The enrollee called on May 10, 2022 and had previously called to get assistance finding a Spanish-speaking therapist on April 4, 2022.[142] The enrollee stated in the call that they would like assistance finding a behavioral health provider who speaks Spanish near their home or work, and that the providers on the list did not accept Molina coverage or did not return calls. This call lasted 48 minutes and the enrollee sounded discouraged during parts of the call. The agent assisting the enrollee did not document in the call notes whether the enrollee located a provider appointment.

- **LFC_PNI File #37:** The enrollee called previously (date unknown) requesting assistance finding a behavioral health therapist. The enrollee expressed frustration that the list the Plan provided was not accurate. They stated, “the therapists either have no availability or do not take Molina.” They were requesting the Plan to help find a provider and make an appointment since they had called before. The agent assisting the member advised they would email them a new list, and they would need to call the providers on the list to determine if those providers were accepting new patients and whether they accepted Molina coverage. The caller then expressed irritation at being instructed to make calls to determine if the list the Plan provided is accurate and they stated, “That’s not very helpful.”

- **LFC_PNI File #51:** This case involved an enrollee who stated they had called two and a half weeks prior to obtain a list of Behavioral Health providers. The caller stated they would like a new list, as the first three providers on the list did not return calls after they left “multiple messages.” The agent handling the call stated there was one provider in the enrollee’s area, but they were not accepting new patients. The agent then gave the enrollee the provider’s number and advised them that, "if there is an available spot they will take you if someone pulls out. Maybe in a month.”

The above file examples are deficient because the enrollees expressed dissatisfaction because they were unsuccessful in obtaining a behavioral health appointment with providers listed on the Plan’s directory and there was no documentation in the files identifying the expressions of dissatisfaction as grievances, or any handling of the issues as grievances.

[142] LFC_18 File: 11.

TABLE 2

Call Inquiry Files

FILE TYPE	NUMBER OF FILES	LEGAL REQUIREMENT	COMPLIANT	DEFICIENT
Behavioral Health call inquiry files categorized as repeat callers	18	The customer service agent recognized the caller's expression of dissatisfaction and initiated the grievance process	15 (83%)	3 (17%)
Behavioral Health call inquiry provider network inquiry without supplemental audio	33	The customer service agent recognized the caller's expression of dissatisfaction and initiated the grievance process	30 (91%)	3(9%)
Behavioral Health call inquiry provider network inquiry with supplemental audio	20	The customer service agent recognized the caller's expression of dissatisfaction and initiated the grievance process	13 (65%)	7 (35%)

Conclusion: The Department's review of the Plan's policies demonstrated the Plan includes a procedure on how to identify grievances in their customer service staff training. However, the Department's review of the Plan's customer service audit tools and call inquiry files demonstrated the Plan's customer service staff failed to consistently identify enrollee expressions of dissatisfaction and process grievances as required. Therefore, the Department finds the Plan in violation of Section 1368(a)(1).

#16: The Plan was operating at variance with its SB 855 compliance filing.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation:

- Plan *Policy CA-HCS-366 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* (February 15, 2023)
- Plan *Procedure CA-HCS-366.01 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines* (February 4, 2023)
- Plan *Policy CA-HCS-365 Clinical Criteria for Utilization Management Decision Making* (March 29, 2024).

- Plan *Procedure CA-HCS-365.01 Clinical Criteria for Utilization Management Decision Making* (March 29, 2024)

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.[143] Included among the types of documents required to be filed are utilization management policies and procedures.

As required by Section 1352(a), the Plan filed an amendment[144] to its policies and procedures with the Department to demonstrate compliance with SB 855, specifically, Sections 1374.72 and 1374.721. Among other requirements, the Plan was required to revise policies and procedures to ensure compliance with interrater reliability requirements[145] and to ensure that all behavioral health utilization management staff are trained on and consistently apply the NPA clinical criteria.[146] As explained in Violation #s 4, 5, and 6, the Plan failed to demonstrate that it conducted interrater reliability testing on its behavioral health utilization management staff, failed to ensure all behavioral health utilization management staff were trained on the NPA criteria, and failed to demonstrate that it consistently applied the NPA criteria to behavioral health utilization management decisions during the review period.

Conclusion: The Plan's filed amendments stated the Plan would conduct interrater reliability testing on the use of the NPA criteria, that all behavioral health staff would be trained on the NPA criteria, and that the NPA criteria would be used in behavioral health utilization management decisions. However, the Plan operated at variance with those filed policies and procedures by failing consistently to perform those required functions. Therefore, the Plan is subject to discipline under Section 1386(b)(1).

[143] Section 1386(b)(1)
[144] eFiling #20211167
[145] Plan Policy CA-HCS-366 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines (February 15, 2023) & Plan Procedure CA-HCS-366.01 Consistency in Application of Medical Necessity Criteria and IRR Documentation Guidelines (February 4, 2023)
[146] Plan Policy CA-HCS-365 Clinical Criteria for Utilization Management Decision Making (March 29, 2024) & Plan Procedure CA-HCS-365.01 Clinical Criteria for Utilization Management Decision making (March 29, 2024)

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

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

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

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 provide its enrollees with easily accessible information about how to obtain routine, urgent, or emergent behavioral health care.</u>

Summary:

A. Member ID Cards

The Plan's member ID cards do not include access information for behavioral health care. The ID cards do not reference behavioral health services and do not include a telephone number for accessing behavioral health triage and screening services or the Behavioral Health crisis line.

B. Evidence of Coverage (EOC)

The Plan's Evidence of Coverages (EOCs) for 2021, 2022, and 2023[147] describe covered services and how enrollees can access those services. However, the EOCs do not clearly identify how to access behavioral health care, including routine, urgent, or emergent behavioral health care.

[147] The verbiage in the Plan's 2021 and 2022 EOCs is slightly different than the verbiage in the Plan's 2023 EOC.

Page two of the Plan's 2023 EOC includes a Reference Guide, which is a summary of healthcare needs and services and a description of how enrollees can obtain these services. The Reference Guide does not discuss how to access behavioral health services. Although the Reference Guide includes phone numbers for the 24-hour Nurse Advice Line and Customer Support, there is no behavioral health services telephone number and no indication that enrollees should call the Member Services telephone number for information about accessing behavioral health care.

The 2023 EOC describes emergent behavioral health services on page 41 but does not include a phone number to access the services. The EOC does not state, in plain language, how an enrollee would access behavioral health services that do not require prior authorization (and thus medical necessity would be irrelevant).

As part of this investigation, the Plan explained its approach for timely access to behavioral health care:[148]

> "in accordance with Mental Health parity and our overall No Wrong Door approach, Molina members obtain timely access to a behavioral health service through referral from their primary care provider/specialty provider, or self-referral by searching for a behavioral health provider using our Molina Provider Online Directory, or by contacting Molina member services directly for further assistance."

However, the EOC does not include Molina's "No Wrong Door approach" and does not explain, in plain language, how an enrollee may access behavioral health services and whether prior authorization is required or self-referral is allowed.

C. Website

The Department's review of the Plan's website, at Behavioral Health (accessed October 16, 2024), found the site does not identify how to access the Plan's behavioral health crisis telephone line. Instead, the site includes a link to the Nationwide 988 suicide and crisis lifeline site. For non-emergency Behavioral Health Services, the website refers to the Plan's online provider directory, the Member Services phone number, the Nurse Advice Line, and Teladoc. The website does not include a behavioral health-specific telephone line.

D. Other Communications

During interviews, the Plan's Assistant Vice President of Quality reported that the Plan sends its members an annual guide that informs them of how to access healthcare, including behavioral health care. The Department subsequently requested copies of any communications the Plan sends to its members educating them about their specific behavioral health benefits.[149] In response, the Plan acknowledged it did not

[148] In response to the Behavioral Health Questionnaire, Section I. Behavioral Health Services, Question #3.
[149] Document Request # 107.

send any emails and/or letters to enrollees educating them about their behavioral health benefits during the Survey period.

#2: <u>The Plan's lack of clarity as to which behavioral health services require prior authorizations can cause enrollee and provider confusion.</u>

Summary: The Plan has multiple documents that provide information to its providers and enrollees about prior authorization requirements. For providers, the Plan's *Marketplace Prior Auth Code Matrix*[150] includes specific service codes with descriptions. During interviews, Plan staff indicated this document is located in the Provider Portal. Plan staff stated that a provider can enter a code into this matrix and the provider will receive information as to whether authorization is required. Although this list is the most comprehensive, it is only available to contracted providers through the Provider Portal.

The Plan also maintains a prior authorization Quick Reference Guide (QRG)[151] which is used by customer service staff. This guide delineates "the behavioral health benefits by line of business" and details which inpatient and outpatient services require prior authorization and/or concurrent review.[152] The QRG is not available to enrollees.

In response to the Department's request for a list of all inpatient and outpatient behavioral health services for which a prior authorization is required, the Plan provided a third list[153] of services requiring prior authorization. The Department requested clarification regarding use of the additional list[154] and the Plan responded it was created specifically for the BHI and submitted as a quick and self-explanatory guide for the Department to:

> "use when reviewing Inpatient Behavioral Health Services and Outpatient Behavioral Health Services that require Prior Authorization and/or Concurrent Review. This document is not used or relied upon by any Molina department responsible for PA or Concurrent review and instead relies upon and utilizes Molina's PA Code Matrix."[155]

The "Prior authorization" section within the Plan's EOCs[156] states:

> Molina will decide about authorization for a service after receiving the request and all medical information necessary to decide, and for a

[150] BHIUM10_1.
[151] BHIUM 11_1.docx.
[152] Inpatient BH Services: Inpatient Psychiatric Hospitalization, Subacute Detoxification, Residential Treatment, Partial Hospitalization Program Day Program, Electroconvulsive Therapy (ECT) and Psychological/Neuropsychological Testing; Outpatient BH Services, Comprehensive Diagnostic Evaluation
BHT/ABA Functional Behavior Assessment, BHT/ABA treatment initiation, and BHT/ABA treatment continuation.
[153] BHIUM16.xlsx.
[154] Id.
[155] Plan Response to Document Request #96.
[156] Listed in violation #3.

> complete list of covered services that require Prior Authorization please visit www.MolinaMarketplace.com or call member services.

This wording in the EOC does not contain clear and plain language that would be easily understood by an enrollee about which behavioral health services require prior authorization. As mentioned in Barrier # 1, the Plan states it has a "No Wrong Door" approach and that enrollees may self-refer for behavioral health care. 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 denials of or issues accessing such services.

Additionally, it was extremely difficult for the Department to find a "complete list of covered services that require Prior Authorization" by visiting the Plan's general website cited in the EOC. This information was eventually located on the Plan's California Marketplace Provider Manual website[157] and includes a "Prior Authorization LookUp Tool" for outpatient services by CPT/HCPCS code.

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 appropriate and timely care.

#3: The Plan's case management program does not actively assist enrollees in accessing behavioral health services.

Summary: The Plan's Case Management (Medi-Cal & Marketplace) policy[158] states the Plan offers Case Management to enrollees who "require extensive use of resources and would benefit from well-coordinated care." The Case Management policy[159] further states the Plan "proactively identifies members who need Case Management using a variety of clinical care processes and data sources.

File Review

The Department reviewed a sample of five In-Depth enrollee files. The Department's file review 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. In three files[160], Case Management was involved but the files failed to show consistent or active participation and interventions by the Case Managers.

[157] https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Provider-Forms.aspx#priorauthorization
[158] Plan Case Management (Medi-Cal & Marketplace) CM-04: May 29, 2024.
[159] Reassessment schedules depend on the complexity and/or stability of member's situation. For example, if the member has transitioned from one level of care to another or has experienced a significant medical (e.g. stroke) or life event (e.g. eviction leading to homelessness) that could impact their ability to manage their health, a schedule for follow-up, communication with the member and reassessment is established by the case manager. System generated reminders (tasks) may be set in accordance with the agreed upon schedule and plan of care.
[160] In-Depth File #2, In-Depth File #4 and In-Depth File #5.

- **In-Depth File #1**[161]**:** An adult enrollee required treatment related to an eating disorder between the dates of March 1, 2022, and February 28, 2023. During this time, the enrollee presented to the Emergency Department twice and was admitted into a Residential Treatment Center program for eating disorders. Case Management documented information about these events but did not actively assist the enrollee in obtaining care nor was Case Management proactive in arranging or even becoming aware of discharge needs to prevent deterioration of the enrollee's status or to ensure continuation of care. There were multiple requests for lists of providers, but no documented action by the Case Manager to contact providers to assist the enrollee. During conversations with Case Management, the enrollee indicated medications had been denied or rejected. However, no follow-up was documented by the Case Manager to assist the enrollee or even inquire as to the reasons for these denials or rejections.

As an example, within the file was a notice of approval for 14 days of Residential Treatment Center services dated July 29, 2022, which included the statement: "contact Molina when the enrollee is ready to be discharged to assist with the discharge planning." A Case Manager note dated August 8, 2022, indicates that the Case Manager found through a call with the treatment center that the enrollee had been discharged on August 4, 2022, against medical advice. The Case Manager then spoke with the enrollee on August 8, 2022, and the enrollee asked about other treatment options including a different facility. The Case Manager advised they would inquire about options for a treatment facility, but there was no documentation demonstrating that the Case Manager did anything.

Although the Case Manager was following the enrollee through the treatments, the entries and activities are passive tracking of information and do not demonstrate that the Case Manager was actively assisting the enrollee in getting care. The enrollee chose to change health plans, and information was not available after February 28, 2023.

- **In-Depth File #3**[162]**:** An adolescent enrollee required treatment related to a depressive disorder, post-traumatic stress disorder and an anxiety disorder between the dates of August 2021 through April 2022.

The enrollee needed mental health services following treatment in an intensive outpatient program (IOP). A call was received from a residential treatment facility to inquire about benefits, and the guardian spoke with the Case Manager and the behavioral crisis line about getting a psychiatric hospital placement on April 5, 2022. The file did not include any documentation of coordination by the Plan with providers for care or assisting the enrollee in receiving services. The Case Manager documented on April 13, 2022, that "they have called many places looking for a facility," and the Case Manager provided referral information to other facilities and resources to the guardian. In notes dated April 20, 2022, the Case Manager indicated that the enrollee has an intake interview with a facility, and they were still trying to find

[161] In-Depth file #1.
[162] In-Depth File #3.

a place for the enrollee. The Case Manager provided the guardian with a list of psychiatric hospitals that were covered by the Plan.

In these files, the Case Managers tracked the activities of the enrollees but did not become actively involved in assisting the enrollees. There was no evidence of care coordination when the enrollees had a change in clinical status or life events, or screening as described in the Plan's policy documents. These shortcomings in the Plan's Case Managers are similar to the Case Managers role discussed in Violation # 2 above. In Violation # 2, the Case Managers are not actively assisting enrollees in finding timely appointments, and here the Case Managers are failing to actively assist enrollees transitioning from one type of treatment to another.

Behavioral Health Crisis Line Callers and Case Management

The Department also reviewed the operations of the Plan's behavioral health crisis line.

The Plan described that a Case Manager completed an outreach call to members who contacted the behavioral health crisis hotline in a narrative which stated:[163]

> It is the policy of MHC to provide a Behavioral Health Crisis Hotline and Nurse Advise Line available 24-hours per day, 7-days per week, 365 days per year for Members. The call logs are reviewed daily and assigned for care management follow up. The goal is to follow up with Members within 1-3 business days from the date that the call log is populated. The optimal goal is 1 day follow-up, when possible. The care manager completes the outreach call to the member for screening and assessment.

In response to the Department's request for evidence of the Plan's oversight of its behavioral health crisis line, the Plan provided a spreadsheet for the Nurse Advice Line and the Behavioral Health Crisis Line Dashboard. The Plan also provided 39 files as evidence of follow-up on the 56 callers to the behavioral health crisis line. Files were not provided for 17 of the callers. The Department's review of the 39 files identified inconsistent efforts were made by Case Managers to contact the enrollees, with some Case Managers making one call with a voicemail left before closing and some Case Managers making multiple calls until the enrollee was reached. There was also inconsistent Case Manager assistance; some provided lists of providers, some called providers with the enrollee, and some tracked information provided by the enrollee only. The files demonstrated that Case Managers did not contact the enrollee's primary care or treating physician for care coordination.

Case Examples

- **File from Behavioral Health Crisis Dashboard Follow-up**[164]**:** The enrollee contacted the behavioral health crisis line on July 9, 2021 seeking "brief support

[163] Plan Response to Document requests #141_#142.
[164] Plan Response to Document Request #141_Folder 1: All of the files from the BH Crisis Dashboard were provided with the enrollee name as the file name, so unable to identify them in this report by specific file name.

and access to services due to substance use and suicidal ideation". A Case Manager was assigned to follow up on this call. A review of the file indicates the enrollee was not contacted by a Case Manager until July 19, 2021.

- **File from Behavioral Health Crisis Dashboard Follow-up:** This enrollee's parent contacted the Plan on April 7, 2021. The Plan documented that parent was seeking counseling and "immediate support or her 18-year-old son who mentioned thoughts of killing himself and killing his family yesterday". The Plan documented level of care as urgent. April 29, 2021 was the first documented attempt to contact the enrollee. The Case Manager made two additional attempts on April 30, 2021, and May 14, 2021, after which a letter was sent and referral was closed.

  File from Behavioral Health Crisis Dashboard Follow-up: The enrollee contacted the behavioral health crisis line on March 28, 2022, seeking support for thoughts of suicide related to being unable to obtain psychiatric care. On April 1, 2022, a Case Manager contacted the enrollee. The enrollee stated they were able to get an appointment for April 12. The enrollee indicated they were homeless. The Case Manager noted a plan to check in with the enrollee in a couple more weeks.

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

Summary: The Plan did not provide evidence it is addressing issues identified during provider satisfaction surveys which may indicate operational challenges and their potential impact on the provision of behavioral health services. According to documents[165] reviewed, the Plan's providers had an overall satisfaction rate of 53.5% with the Plan's operational areas surveyed for 2022. As noted by the Plan in its 2022 Provider Satisfaction Survey Findings Report, when compared to provider satisfaction with all commercial plans in California for 2022, the Plan's overall provider satisfaction rate puts it in the 18.3% percentile.

Although some operational areas are improving, according to the Plan's 2022 *Provider Satisfaction Survey Findings document*, 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

[165] 2022 Provider Satisfaction Survey Findings Report

providers, and communication with specialists. Compared to 2021, provider satisfaction in this area worsened.

Health Plan Call Center Service Staff: This surveyed area includes topics such as ease of reaching health plan staff on the phone, process of obtaining member information and helpfulness of call center staff. Compared to 2021, provider satisfaction in this area worsened. Although the Plan's provider satisfaction rates declined from 2021 to 2022 in most areas surveyed, and, as noted by the Plan in its 2022 Provider Satisfaction Survey Findings Report, was low overall as compared to all other commercial plans in the state,[166] the Plan failed to provide evidence it was addressing issues raised by providers. The failure of the Plan to address provider dissatisfaction may contribute to a myriad of issues, such as providers no longer accepting Plan members, loss of in-network providers and access issues for enrollees.

Furthermore, the 2022 Provider Satisfaction Survey indicates only 8.4% of behavioral health care specialists responded to the survey,[167] 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 improvement in the above areas nor did the Plan provide specific analysis related to behavioral health services.

#5. <u>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.</u>

Summary: The Plan's Grievance and Appeal Log demonstrated that 83 out of 101[168] (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,[169] 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 a 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

166 2022 Provider Satisfaction Survey Findings Report
167 Id.
168 LFF_Log F G&A.xlsx.
169 LFF_Log F G&A.xlsx; Column K (Category of the grievance or appeal)

subcategories, it does not appear to the Plan that there is a trending issue with access to psychiatrists.

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, the enrollee was having difficulty obtaining a psychiatrist appointment. This issue was categorized with three different combinations of subcategories. In 29 of 102 (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.

#6. The Plan does not have a system to accurately track and trend repeat callers having difficulty obtaining behavioral health appointments.

Summary: The Department requested the Plan to describe how it manages repeat callers.[170] The Plan provided a written response indicating that the incidence of repeat callers with behavioral health issues is "very small." The Plan also provided a sample repeat caller report, which included seven repeat callers that had been received by the Plan in the prior 60 days along with a statement:

> Repeat calls often reflect typical member behavior, such as contacting for different inquiries within the 60-day period, which may not indicate any issues. Consequently, the Top Repeat Caller Report includes a broad range of member interactions.

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. This demonstrates the same issue the Department identified during review of the Plan's behavioral health call inquiry files and discussed in Violation #1 and Violation #15.

By not having a system to accurately track and trend repeat callers, the Plan is unable to monitor instances in which callers are not getting the assistance they require and therefore 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.

[170] Document request #113.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified 16 Knox-Keene Act violations and six 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 fact.

The Plan may submit a statement describing actions the Plan has or will take to address the seven 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 Thursday, October 9, 2025, using the DMHC Web Portal process described below.

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 16 identified Knox-Keene Act violations.

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 eFiling link.
- Click the Online Forms link
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2024 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

Name	Title
Holly Pearson	Assistant Chief Counsel
Owen Zion	Attorney III
Tammy McCabe	Attorney IV
Jennifer Sharifi	Attorney III
Oksana Meyer	Assistant Deputy Director, Division of Plan Surveys
Kimberly Galli	Staff Services Manager II, BHI Manager
Nakisha Willis	Health Program Specialist II, Team Lead

CONSULTANT TEAM MEMBERS: MAXIMUS FEDERAL SERVICES, INC.

Name	Title
Kathleen Lockwood	Project Manager/Esq,RPh
Andrew Mendonsa	Investigator/Psy.D
Sherri Field	Investigator/RN
Alesandra Beers	Investigator/RN
Carol Brooke	Investigator/RN
Zyanya Mendoza	Investigator/Psy.D
Julie Morgan	(Observer)/LCSW

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: MOLINA HEALTHCARE OF CALIFORNIA

Name	Title
Abbie Totten	Plan President
John Kotal	COO
Matt Levin	VP, Government Contracts
Dr. Sayeed Kahn	Chief Medical Officer
Veronica Mones	R.N., VP, Healthcare Services
Brennon Jackson	AVP, Appeals & Grievances
Robert Williams	Director, Appeals & Grievances
Torriaun Everrett	Director, Appeals & Grievances
Irene Armendariz	VP, Claims
Julissa Bravo	Director of Claims
Andria Morud	Director of Claims
Tanya Contreras	AVP, Claims
Anna Wright	Director, Member Services
Annie Roh	Pharmacy Manager
Kristen Kidwell	AVP, Quality
Vantrese Tompkins	VP, Clinical Operations
Victoria Luong	Director Health Equity & Cultural Competency
Diana Sekhon	AVP, Government Contracts

Name	Title
Kristin Rosemond	AVP, Network Strategy & Services
Nathan Reiter Garcia	Director, Health Equity & Cultural Competency
Dr. Gregory Gale	Sr. Medical Director
Frank Vemaza	Director, Claims
Dr. F. Joseph Hullett	Medical Director of Behavioral Health
Neeta Alengadan	AVP, Healthcare Services
Randy Nater	Director, Behavioral Health
Katie McMahon	Director, Quality
Sonia Hernandez	Director, Healthcare Services
Corrianne Dockter	Director, Credentialing
Colin Hunter	Director, Provider Network Admin
Caroline Wroblewski	AVP, Healthcare Services
Dr. James Kyle	Sr. Medical Director, Quality & Health Equity
Angelee Smith	Director, Provider Contracts
Sonya Araiza	VP, Network Management
Christina Ciciarelli	VP, Operations
Ruby Silva	Director, Healthcare Services
Julie Hamilton	Sr. Associate General Counsel
Jordan Yamashita	AVP, Compliance
Carl Breining	Manager, Compliance
Alison Patsy	Program Manager

Name	Title
Robert Williams	Director, Appeals & Grievances
Roshona Hammock	Manager, Appeals & Grievances
Ryan Boe	Director, Provider Data Management
Luis Ruiz	Manager, Clinical Pharmacy
Stephanie Wickersham	Manager, Pharmacy
Tracy Nguyen	Lead Pharmacist
Scott Weeks	Auditor, Compliance

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

A – Utilization Management (UM) Authorizations, Modifications, and Denials for Behavioral Health (BH) Services

LFA_BHUM (Files Reviewed:35)

Plan File #
2109800292
2110600853
2110600853
2113300259
2115900166
2119000267
2119000413
2120290352
2123000177
2128000399
2128501018
2131200356
2134800766
2200300970
2205600287
2207600721
2218500180
2219500117
2220300273

Plan File #
2221600111
2225200238
2225601048
2226500999
2227600591
2231300886
2235600692
2301200333
2305301005
2305400035
2306600345
2307300287
2309400972
2312100213
2313800950
2315191836

Log A FP 1 (Files Reviewed:13)

Plan File #
2121600477
2227900917
2233200425
2304800696

Plan File #
2202700421
2134300987
2309000696
2222800230
2131600230
2300400166
2313600252
2112300172
2314400460

Log A FP 2 (Files Reviewed: 3)

Plan File #
2235200146
2204501188
2129300506

Log A FP 3 (Files Reviewed: 2)

Plan File #
2127101022
2117900260

LFA_GF (Files Reviewed: 30)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Reference ID #
33
122
112
128
125
29
87
28
78
83
113
110
40
93
51
118
50
4
23

Reference ID #
86
61
20
32
60
109
14
59
80
96
27

LFA_CNS (Files Reviewed: 30)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
102
71
79
60
29
87

Plan File #
20
62
38
80
61
104
52
3
33
105
63
97
37
9
99
108
14
32
59
74
44

Plan File #
100
91

LFA_SUBL (Files Reviewed: 3)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3

LFA_SPRA (Files Reviewed: 4)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3
4

LFA_LUC (Files Reviewed: 1)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1

LFA_HCO (Files Reviewed: 9)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3
4
5
6
7
8
9

LFA_DT (Files Reviewed: 9)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3
4
5
6
7

Plan File #
8
9

LFA_BUP (Files Reviewed: 5)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3
4
5

LFA_AYTP (Files Reviewed: 6)

Please note – All case files listed in this section include the Reference ID # since a File ID # was not provided. Please refer to the BHI File Selection spreadsheet submitted to the Plan on 12/21/23 for verification of the case files listed below.

Plan File #
1
2
3
4
5
6

B – Benefit/Coverage/Experimental Denials of Behavioral Health Services

Log B FP 1 (Files Reviewed: 8)

Plan File #
2131525904
23073186734
21144293868
21365264208
22105241359
22168233423
21118281031
22346464116

Log B FP 2 (Files Reviewed: 2)

Plan File #
21099377632
22189222490

Log B FP 3 (Files Reviewed: 6)

Plan File #
23081175501
23053156361
21223280412
22076107968
21193207791

Plan File #
21175224960

Log B FP 4 (Files Reviewed: 2)

Plan File #
21172374045
21133291031

C – Enrollee Inquiry Contacts

LFC_18 (Files Reviewed: 18)

Plan File #
14502395 / SF2659905
15219823 / SF2993424
15315893 / SF3019886
17944053 / SF4276911
18053229 / SF4389653
18425393 / SF4564620
19343127 / SF4752720
19371178 / SF4784836
25665882 / SF7903484
26581656 / SF8616927
27016450 / SF8793057
28556011 / SF9950548
32798753 / SFA12936763

Plan File #
37574323 / SFA15935111
59512267 / SFA22612757
61769594 / SFA23806441
62548560 / SFA24434489
63648919 / SFA24908689

LFC_PNI (Files Reviewed: 52)

Plan File #
C00020390392
13040766 / SF2277105
13265055 / SF2299096
14786293 / SF2825553
15329544 / SF3035629
15339570 / SF3039331
15445151 / SF3137940
15529945 / SF3232925
15581248 / SF3280983
15926049 / SF3366412
16061218 / SF3497479
16127420 / SF3556374
16136217 / SF3561900
16346027 / SF3701092
16699801 / SF3913202

Plan File #
16817559 / SF4037365
16840560 / SF4065041
17938665 / SF4270318
18008906 / SF4349418
18064628 / SF4408552
18354073 / SF4493616
18356042 / SF4496470
19126944 / SF4623607
19287186 / SF4691047
19338077 / SF4746297
19574429 / SF4998480
20706537 / SF5497901
22780134 / SF6408096
24114950 / SF6989085
24686812 / SF7282985
24705807 / SF7306292
24970801 / SF7532726
25158318 / SF7701997
26266126 / SF8277747
27020410 / SF8798510
27068694 / SF8857713
27280434 / SF9055606
27475070 / SF9216276

Plan File #
27517877 / SF9255402
27816347 / SF9577730
29055943 / SF9265655
29337371 / SF10622279
31832691 / SFA12093944
32032100 / SFA12260037
32368803 / SFA12722836
33740880 / SFA13281428
33795331 / SFA13365079
34040987 / SFA13708623
36380218 / SFA15079572
53473333 / SFA20029281
58880664 / SFA22321048
65802875 / SFA25371923

LFC_BI (Files Reviewed: 39)

Plan File #
15030407 / SF2916949
15503982 / SF3203718
15568391 / SF3269069
16313782 / SF3663953
16473537 / SF3839689
16700402 / SF3913886

Plan File #
16867932 / SF4095075
18276313 / SF4446964
18353601 / SF4493074
19106355 / SF4599291
19460316 / SF4868011
19536474 / SF4954806
19889357 / SF5229784
20363460 / SF5340538
20636682 / SF5444308
20760783 / SF5518016
21584579 / SF5867603
21612327 / SF5887108
21986437 / SF5914544
22075215 / SF5979501
22147585 / SF6035048
23062870 / SF6531174
25697263 / SF7934405
25804830 / SF7997583
26025351 / SF8145523
39244031 / SFA17115420
39689880 / SFA17686079

Plan File #
49131197 / SFA17850439
50533270 / SFA18288489
51420919 / SFA18690039
52258224 / SFA19422279
53500474 / SFA20071205
54192070 / SFA20796674
55124720 / SFA21019386
55563260 / SFA21309547
58880903 / SFA22323139
59545027 / SFA22653841
62164678 / SFA24011953
66981886 / SFA26103203

E – Provider Complaints and Disputes

LFE_PYMNT (Files Reviewed: 21)

Plan File #
PRV-1319226
PRV-469784
PRV-1322709
PRV-1319206
PRV-1319196
PRV-1322691

Plan File #
PRV-1323841
PRV-1323837
PRV-146947
PRV-1076075
PRV-1647084
PRV-772496
PRV-1319233
PRV-1647059
PRV-469798
PRV-1591604
PRV-464549
PRV-1319169
PRV-1322706
PRV-1444525
PRV-1327488

LFE_AUTH (Files Reviewed: 8)

Plan File #
PRV-145482
PRV-146923
PRV-340360
PRV-844834

Plan File #
PRV-1076130

F – Grievances and Appeals

LFF_AA (Files Reviewed: 25)

Plan File #
MEM-104868
MEM-179343
MEM-133686
MEM-50722
MEM-103088
MEM-199903
MEM-595191
MEM-165748
MEM-199731
MEM-72098
MEM-684797
MEM-117671
MEM-82340
MEM-195256
MEM-219594
MEM-79156
MEM-86596

Plan File #
MEM-82048
MEM-141198
MEM-95995
MEM-285536
MEM-714629
MEM-80886
MEM-172115
MEM-335353

LFF_6 (Files Reviewed: 6)

Plan File #
MEM-199405
MEM-342086
MEM-423945
MEM-546231
MEM-574015
MEM-685964

LFF_14 (Files Reviewed: 14)

Plan File #
MEM-77761
MEM-102282
MEM-102416

Plan File #
MEM-107579
MEM-143748
MEM-159856
MEM-161952
MEM-174274
MEM-183614
MEM-183663
MEM-296456
MEM-296702
MEM-311248
MEM-567638

H – Claims for BH Services

LFH (Files Reviewed: 31)

Plan File #
23013414122
22094300811
22035233796
22221318517
23059537039
22055300593
23088363185

Plan File #
22265150472
21299394837
23108197420
22090403057
21137000032
23054144584
22263473332
22074284855
23101215885
23135290626
22360390115
22097426465
23136156710
21249331377A1
22304284409
22245237136
22124203084
22157297067
22125252727
21204282247
22196237340

Plan File #
22171319691
23072341031
22188252948

I – Potential Quality Issues

LFI (Files Reviewed: 2)

Plan File #
24413
29751

J – BH (MH/SUD) ER Services

Log J FP (Files Reviewed: 15)

Plan File #
2226100121
2235200146
2309700209
2118200191
2116600921
2224200068
2304800696
2110300936
2235000438
2210500807
2120100918

Plan File #
2202100835
2208000904
2302700789
2114500527

M – Enrollee Requests for Out-of-Network Coverage for a Behavioral Health Provider

LFM (Files Reviewed: 30)

Plan File #
2219500117
2221600149
2227801080
2229900750
2222800230
2309400972
2200700850
2229900750
2131200356
2126300201A
2231300886
2223100160
2232192596
2211791389

Plan File #
2131200356
2217900106
2227101044
2131300511
2206701389
2314691676
2232100059
2110600853
2117300757
2119000267
2200600450
2222391860
2223100160
2206701389
2207701343
2218500086

LFM_52 (Files Reviewed: 7)

Plan File #
2307300287
2307300287
2307300287

Plan File #
2312100213
2312100213
2312100213
2312100213

Molina Healthcare of California
Corrective Action Plan Response

Corrective Action Plan Response Form

Plan Name: Molina Healthcare of California

Audit Name: 2023 Focused Behavioral Health Investigation (BHI) Review Period: April 1, 2021 – May 31, 2023

Deficiency Statement #1	The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services and through grievances and appeals. Statutory/Regulatory Reference(s): Section 1367.27(j)(3), (o)(1) and (o)(2)(B)
Action(s) Taken	**Contact Center:** To address the issue identified, the following actions have been implemented to ensure all agents are aware of the correct procedures for submitting iServe tickets for inaccuracies in the POD and for submitting grievances: Annual Refresher Training for Leaders and Cascade to Agents: Annual refresher sessions were conducted in October 2024 and October 2025, during which leaders were reminded of the correct process and were tasked with cascading this information to their respective teams. The meeting agendas provided confirm that these refresher sessions took place and included guidance on: • How to submit iServe tickets for POD inaccuracies. • When and how to submit grievances. Agent Acknowledgement of Understanding: A sign-off sheet was distributed and completed by agents, confirming that each has reviewed and understands the process for submitting iServe tickets and grievances. These actions ensure that all staff members are informed and aligned with the correct procedures, helping to reduce future errors and improve overall compliance. **Appeals & Grievances:** The Plan provided refresher training to the team to ensure provider directory inaccuracies are identified and resolved in accordance with the established timeframes. After refresher training was provided, monitoring reports were pulled to ensure that staff are successfully following the process. The Plan confirmed that staff are identifying and reporting provider directory inaccuracies as required. Monitoring will continue on a quarterly basis to ensure the reporting of provider directory inaccuracies.

	Provider Data Management: Provider Data Inaccuracy iServe tickets, submitted by Member Services or Appeals and Grievances, are reviewed daily by the Provider Data Management (PDM) team. Each PDM associate triages assigned tickets by examining the reported data issue in both the Provider Online Directory (POD) and QNXT, Molina's system of record. If discrepancies exist, the associate contacts the provider to verify information and determine accuracy. Research may involve phone verification, provider websites, or internal tools like Conga for contract or credentialing validation. PDM updates data in QNXT according to the plan's business rules. Immediate updates appear in the directory the next day, while items requiring plan review are temporarily removed until verified and approved for update. Please see the document titled "***DEF1F_Provider Data Inaccuracy Flow 2025***".
Supporting Documentation	• DEF1 Internal Communication • DEF1 POD Monitoring Report • DEF1 Refresher Training • DEF1A_iServe Request for POD Data Inaccuracy Correction • DEF1F_Provider Data Inaccuracy Flow 2025 • IServe Request for POD Data Inaccuracy Correction • SWAT Meeting Agenda – 10/24/2024 • SWAT Meeting Agenda – 10/16/2025 • Grievance-POD Sign Off
Implementation Date* (Anticipated or Completed)	Appeals & Grievances: Implemented 7/17/2025 Contact Center: Implemented 10/2025
DMHC Comments	

Deficiency Statement #2	The Plan's processes fail to ensure that enrollees are offered appointments within the timely access standards when they call the Plan or submit grievances about requesting behavioral health appointments. Statutory/Regulatory Reference(s):

	Sections 1367.03(a)(1), (a)(5)(D), (E), 1368(a)(1) and Rule 1300.67.2.2(b)(2), (c)(5)(D), (E)
Action(s) Taken	**Appeals & Grievances:** The Plan provided refresher training to staff members regarding the requirement of obtaining confirmation of offered appointments to enrollees to ensure the timely access standards are met. **Case Management:** The current process is that Case Managers educate or refer members to Teladoc or Care Connections for urgent access appointments to meet timely access standards. Steps taken to remediate the concern are documented in the file and communicated to the Grievance staff for closure as outlined in desktop guides.
Supporting Documentation	• DEF2 Refresher Training – Timely Access Appointments
Implementation Date* (Anticipated or Completed)	Implemented 10/15/25
DMHC Comments	
Deficiency Statement # 3	The Plan fails to consistently arrange for the timely provision of out-of-network behavioral health care for its enrollees. Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), (a)(5)(A), (B), (C), (D), (E) and (F), 1374.72(d), and Rule 1300.67.2.2(c)(1)
Action(s) Taken	**Appeals & Grievances:** The Plan provided refresher training to staff members regarding the requirement of obtaining confirmation of offered appointments to enrollees to ensure the timely access standards are met. **Case Management:** The current process is that Case Managers educate or refer members to Teladoc or Care Connections for urgent access appointments to meet timely access standards. Steps taken to remediate the concern are documented in the file and communicated to the Grievance staff for closure as outlined in desktop guides.
Supporting Documentation	• DEF3 Refresher Training – Timely Access Appointments
Implementation Date*	Implemented 10/15/25

(Anticipated or Completed)	
DMHC Comments	
Deficiency Statement # 4	The Plan lacks a process to conduct interrater reliability (IRR) testing for its behavioral health utilization management staff to ensure consistency in application of the nonprofit association (NPA) criteria and could not demonstrate such staff were achieving IRR pass rates of at least 90 percent. Statutory/Regulatory Reference(s): Section 1374.721(e)(5), (6) and (7)
Action(s) Taken	Recognizing that the IRR process is for BH cases overall and not specific enough to evidence the Plan's compliance with the use of NPA criteria, the Plan is in the process of modifying the IRR process to include cases that require NPA criteria to be administered to all clinicians (nurses and MDs). A minimum passing score of 90% will be required.
Supporting Documentation	No documentation to provide at this time – IRR questions are currently in development.
Implementation Date* (Anticipated or Completed)	Anticipated: Q4 2025
DMHC Comments	
Deficiency Statement # 5	The Plan is unable to demonstrate that all staff who conduct behavioral health utilization management reviews attended and completed the required formal training on nonprofit professional association (NPA) criteria. Statutory/Regulatory Reference(s): Section 1374.721(b) and (e)(1)
Action(s) Taken	The Plan has implemented a follow up and escalation process to adequately capture and report all staff who have attended and completed the required formal training on nonprofit professional association (NPA) criteria. The staff and MDs are notified of the training requirements upon hire and annually thereafter, or as needed if there are changes, modifications or new releases/editions of the criteria that require training. The staff are required to report on their training completion dates for tracking in the master grid/roster. Moving forward, if staff do not provide completion dates as requested,

	the incomplete information is escalated to their direct manager and department leader for follow-up and intervention. Staff are subject to coaching and disciplinary action at the discretion of their leadership for non-compliance with SB 855 training and reporting.
Supporting Documentation	N/A
Implementation Date* (Anticipated or Completed)	Implemented Q4 2025
DMHC Comments	
Deficiency Statement # 6	The Plan is unable to demonstrate that its behavioral health utilization management staff consistently use the nonprofit professional association (NPA) criteria when required. Statutory/Regulatory Reference(s): Section 1374.721(b)
Action(s) Taken	Molina has implemented a comprehensive training and audit approach specifically for SB 855 that included developing supplemental materials and an audit tool to better support the UM and clinical decision-making staff. The Clinical Training team partnered with our BH Medical Director to develop materials and tools that supplement the training delivered directly by the non-profit association to Molina staff. This approach enabled the plan to better operationalize the content and information within the health plan's UM process. The monthly internal review and audit process was developed by the internal auditing team, in partnership with the Clinical Training and Utilization Management leadership and implemented to ensure that staff is actively utilizing the criteria during the review process. This is separate and distinct from the IRR process to ensure more real time tracking and compliance.
Supporting Documentation	• DEF6_Senate Bill 855 presentation.pptx • DEF6_Training Attendance Report.xlsx
Implementation Date* (Anticipated or Completed)	Training – Implemented: Q1 2025 Case Auditing – Implemented: 10/2025 (retro-review of cases back to January 2025)
DMHC Comments	

Deficiency Statement # 7	The Plan's policies and procedures for post-stabilization services are inconsistent with Knox-Keene Act requirements. Statutory/Regulatory Reference(s): Sections 1371.4(d), (j)(1) and (j)(2)(B) and 1262.8(b)(3), (d)(1), (d)(2) and (o), and Rule 1300.71.4(b)(1), (b)(2) and (c).
Action(s) Taken	The plan is in active discussions with DMHC regarding post-stabilization protocols. As a result of this ongoing dialogue, the Plan has updated its policy and procedure for post-stabilization care in accordance with post-stabilization statutory requirements as referenced in H&S Code 1371.4. The Plan has submitted these updated policies and procedures to DMHC and is awaiting approval. E-Filing No. 20251658
Supporting Documentation	• MCA-HCS-302.01.02d Post Stabilization Services Procedure Addendum (Medicaid, Medicare, DSNP)_rL • UM-89 ER Stab Post Stab Care_rL (3)
Implementation Date* (Anticipated or Completed)	N/A
DMHC Comments	
Deficiency Statement # 8	The Plan fails to consistently ensure appropriate discharge planning for enrollees. Statutory/Regulatory Reference(s): Sections 1367(d), 1367.03(a)(5)(F) and 1374.72(d)
Action(s) Taken	The Plan has submitted a rebuttal for this finding, which is currently under review by DMHC.
Supporting Documentation	• DMHC Memo for Finding 8.1.pdf • BHI Case File Production Instructions.pdf
Implementation Date* (Anticipated or Completed)	N/A
DMHC Comments	
Deficiency Statement #9	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. Statutory/Regulatory Reference(s): Sections 1374.721(a), (b), (c), (f)(1) and (4),1367.01(h)(4), 1363.5(a), (b)(2)(4) and (5).
Action(s) Taken	The Plan received approval from DMHC to utilize the VA DoD clinical guidelines for the review of TMS Treatment requests, as stated in the memo dated 06/19/2024, which was submitted in response DMHC Request #32 to address audit elements BHIUM7, BHIUM16 and BHIUM17. As explained in the memo, the guidelines do not describe variations in treatment based upon the individual treating clinician's judgment nor internal utilization management processes that vary from entity to entity. They describe presenting circumstances, for which scientific evidence supports possible effectiveness of an intervention, and describe various supported intensities and methods of treatment and various endpoints after which the treatment may no longer be supported. However, the guidelines cannot predict response to treatment. Given the application of TMS treatment, the Plan explained our process for authorization, which is to authorize half the expected timeframe and then check in to see if the member is still in treatment, has other care management needs, developed adverse effects, etc. The case files for TMS reflect the processes as outlined in the memo, stating that the Plan approves half of the expected/requested sessions to determine if the treatment is working and that the treating provider can request the additional sessions if treatment has proven effective/successful. The Plan has updated its process to approve the TMS treatment sessions as requested, if medically necessary per the VA DoD guidelines, without any modification. Additionally, the BH MD will work with the BH reviewers to ensure that the appropriate NPA criteria are cited for all TMS cases.
Supporting Documentation	• DEF9_TMS Treatment Memo Submitted

Implementation Date* (Anticipated or Completed)	Anticipated: Q4 2025
DMHC Comments	
Deficiency Statement # 10	The Plan does not adequately oversee its behavioral health triage and crisis line delegate. Statutory/Regulatory Reference(s): Section 1367.03(a)(8) and (e) and Rules 1300.67.2.2(c)(8), (b)(19) and (b)(20) and 1300.70(b)(2)(B)
Action(s) Taken	Accountability and Oversight transferred from the Core Operations Team/Call Center Team to the Clinical Operations Department and to the Delegation Oversight Department in Q3 2023. a. Clinical Operations Department Oversight Activities: i. Quarterly Business Review ii. Weekly Touch Base Calls with Vendor iii. Monthly Monitoring and Review Service Level Agreements and Key Performance Indicators 1. CA Marketplace Scorecard b. Delegation Oversight Department Auditing and Monitoring Activities: i. Annual Audit 1. Policy and Procedure Review 2. Call Review Audits 3. Audit of Carenet's Oversight of ProtoCall 4. Carenet's Health Call Center NCQA Accreditation ii. Monthly Review of Behavioral Health Call Center Metrics iii. Corrective Actions iv. Delegation Oversight Committee Governance c. Health Plan Activities i. Follows up with members with Behavioral Health crises to ensure mitigation of member crisis and timely, imminent emergent, and urgent access to appropriate providers ii. Identifies when additional assistance or crisis services/emergency medical services must be contacted to provide further assistance to members with Behavioral Health crises

Supporting Documentation	• DEF10A_Quality Business Review_Carenet Q2 2025 • DEF10B_Carenet Statement of Work No 3_Behavioral Health • DEF10C_Clinical Vendor Performance – CA August 2025 Marketplace Scorecard • DEF10D_2025 Jan- Sep Report of BH Call Center Metrics – CA Marketplace • DEF10E_2025 CA Carenet Annual Audit Summary • DEF10F_NCQA - Carenet Health • DEF10G_2024-25 Carenet Corrective Action Plan Summary_CA Marketplace • DEF10H_National Delegation Oversight Committee Minutes 9.24.25 • DEF10I_ HCS-645.01 Behavioral Health Crisis Protocol for Clinical and Non-Clinical Staff Procedure • DEF10J_Managing Behavioral Health Crisis Situations Quick Reference Guide_05.19.25 • DEF10K_03_Behavioral Health Crisis Call Work Queue Assignment Quick Reference Guide • DEF10L_Policy No. UM-95 Senate Bill 855 - CA Marketplace • DEF10M_Carenet - Protocol Monthly Utilization Report Example • DEF10N_ProtoCall Carenet Daily Call Report Example • DEF10O_Carenet Molina Monthly QA Review - Supervisor QA Sep 2025
Implementation Date* (Anticipated or Completed)	Implemented 10/20/2025
DMHC Comments	
Deficiency Statement # 11	The Plan fails to monitor and take effective action to correct identified timely access issues. Statutory/Regulatory Reference(s): Section 1367.03(a)(1) and Rule 1300.67.2.2(c)(1), 1300.70(a)(1), (3) and (b)(1)(B)
Action(s) Taken	The plan conducts routine monitoring of its provider network through timely access surveys to assess provider compliance with timely

	access standards. To effectively take action to address the timely access issues found through these monitoring surveys, the Plan conducts targeted training and resurveys the non-compliant providers. After resurvey, providers still found non-compliant are issued a corrective action plan which the Plan tracks to review for ensuring the issues are resolved for compliance with timely access standards. The plan submits its revised policies and procedures for the monitoring and corrective action plan escalation process.
Supporting Documentation	• MCA-NC-14: Network Adequacy, Availability, and Accessibility Policy • MCA-NC-14.01: Network Adequacy, Availability, and Accessibility Procedure • MCA-NC-14.01.1a: Network Adequacy, Availability, and Accessibility Procedure • MCA-NC-14.01.2b: Network Adequacy, Availability, and Accessibility Procedure • MCA-NC-09: Timely Access to Care Policy • MCA-NC-09.01: Timely Access to Care Procedure • Mark Welch CAP
Implementation Date* (Anticipated or Completed)	Implemented Q4 2024
DMHC Comments	
Deficiency Statement # 12	The Plan fails to ensure that credentialing applications for behavioral health providers are confirmed, assessed, and verified as required. Statutory/Regulatory Reference(s): Section 1374.197(a)
Action(s) Taken	A system flag was created for Behavioral Health specialties to drop them into a separate processing queue. Files in the queue receive automatic notification of credentialing kick-off and follow up notification of missing information within 7 days of receipt of the application. All files are monitored against the 60 day turnaround time requirement. As an additional check and balance, a dashboard is being developed that will allow 3 non-Production staff to monitor any submissions for Behavioral Health specialties and ensure the Behavioral Health flag is present. Files missing the flag will then be re-routed to the correct

	queue to ensure all required notifications occur, and all files meet the 60-day turnaround time requirement.
Supporting Documentation	• DEF12A_CA TAT Report 2025 - (Turnaround time report of 2025 processing) • DEF12B_ Application Receipt Notifications - (Examples of notifications sent to practitioner)
Implementation Date* (Anticipated or Completed)	Implemented 2/24/2025
DMHC Comments	
Deficiency Statement # 13	The Plan does not adequately monitor for trends in over and underutilization of behavioral health care services. Statutory/Regulatory Reference(s): Section 1367.01(j) and Rule 1300.70(a)(3) and (c)
Action(s) Taken	Although over/under utilization is tracked and reported at the Health Care Services Committee meeting on a quarterly basis, the plan recognizes that there are opportunities to better identify and address over/under utilization for behavioral health (BH) services. The Plan has recently developed a BH Provider Outlier Report as part of a Provider Optimization Initiative. This initiative focuses on BH service utilization trends among providers that are outside of the standard or average utilization benchmarks or expectations. The Provider Outlier report is used to identify providers with abnormal utilization patterns, which then triggers an engagement plan and process for follow up by the health plan BH and Provider Relations staff based on the data analysis. This follow up includes meetings and discussion with the provider on their utilization practices and possible education/intervention to support and optimize service delivery. Additionally, the Plan developed a new dashboard for reporting over and underutilization of services and is actively working with our reporting and analytics team to ensure that Outpatient BH services are appropriately captured in this reporting. We anticipate the changes will be in effect for Q1 2026, allowing for development, testing and validation. The results from this dashboard and any associated interventions will be reviewed and discussed in the Health Care Services Committee meeting.

Supporting Documentation	• DEF13_BH Provider Outlier Report
Implementation Date* (Anticipated or Completed)	Anticipated: Q1 2026
DMHC Comments	
Deficiency Statement # 14	The Plan fails to consistently adequately consider all issues within enrollee grievances and provide rectification when appropriate. Statutory/Regulatory Reference(s): Section 1368(a)(1) and Rule 1300.68(a)(4)
Action(s) Taken	The Plan provided refresher training to the team to ensure provider directory inaccuracies are identified and resolved in accordance with the established timeframes.
Supporting Documentation	• DEF14 Internal Communication • DEF14 Refresher Training • DEF14 POD Monitoring Report A&G
Implementation Date* (Anticipated or Completed)	Implemented: 7/17/25
DMHC Comments	
Deficiency Statement # 15	The Plan's customer service staff fail to consistently identify enrollee expressions of dissatisfaction as grievances. Statutory/Regulatory Reference(s): Section 1368(a)(1) and Rule 1300.68(a)(1)
Action(s) Taken	**Contact Center:** To address the issue identified, the following actions have been implemented to ensure all agents are aware of the correct procedures for submitting grievances: Annual Refresher Training for Leaders and Cascade to Agents: Annual refresher sessions were conducted in October 2024 and October 2025, during which leaders were reminded of the correct process and were tasked with cascading this information to their

	respective teams. The meeting agendas provided confirm that these refresher sessions took place and included guidance on: • When and how to submit grievances Agent Acknowledgement of Understanding: A sign-off sheet was distributed and completed by agents, confirming that each has reviewed and understands the process for submitting grievances. These actions ensure that all staff members are informed and aligned with the correct procedures, helping to reduce future errors and improve overall compliance. **Appeals & Grievances:** The Plan provided refresher training to the team to ensure grievances are being filed correctly when member frustration and expressions of dissatisfaction is present. After refresher training was provided, monitoring reports were pulled to ensure that staff are successfully following the process. The Plan confirmed that staff are identifying and reporting member's expressions of dissatisfactions correctly. Monitoring will continue on a quarterly basis to ensure the reporting of members' expressions of dissatisfaction.
Supporting Documentation	• Expedited Grievances and Appeals Medicaid MP CA.pdf • Member Grievance Process Coding and Documenting Grievances MP.pdf • Member Grievance Process Defining and Identifying Grievances MP.pdf • Member Grievance Quick Reference Guide MP CA.pdf • Inquiry vs. Grievance CA.pdf
Implementation Date* (Anticipated or Completed)	Implemented October 2024 and repeated annually in October 2025.
DMHC Comments	
Deficiency Statement # 16	The Plan was operating at variance with its SB 855 compliance filing. Statutory/Regulatory Reference(s): Section 1386(b)(1)
Action(s) Taken	The Plan recognizes that these findings are reflective of the discrepancies between what was submitted to the DMHC during the SB 855 compliance filing process and what was submitted and demonstrated during the DMHC BHI audit. Specifically, the deficiencies identified inconsistencies with the IRR related policies

	and procedures. The submitted remediation plan for Deficiency 4 will address this finding.
Supporting Documentation	No documentation to provide at this time – IRR questions are currently in development.
Implementation Date* (Anticipated or Completed)	Anticipated: Q4 2025
DMHC Comments	