DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

UHC of California
DBA (UnitedHealthcare of California)

JANUARY 9, 2025

Behavioral Health Investigation
UnitedHealthcare 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 UHC of California dba UnitedHealthcare of California (Plan) was included in Phase Three.

On August 12, 2024, the Department notified the Plan of its BHI covering the time period of June 1, 2022 through May 31, 2024. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan, its behavioral health delegate, U.S. Behavioral Health Plan, California (USBHP), dba OptumHealth Behavioral Solutions of California, and its pharmacy benefit manager, Optum Rx on February 25, 2025 through February 27, 2025.

The BHI uncovered 11 Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Grievances and Appeals and Quality Assurance:

1. The Plan fails to ensure USBHP consistently identifies, investigates and documents potential provider directory inaccuracies reported to USBHP's customer service and grievance departments.
2. The Plan fails to ensure USBHP consistently offers enrollees behavioral health appointments within the timely access standards when they call or submit grievances about requesting behavioral health appointments.
3. The Plan fails to ensure USBHP consistently arranges for the timely provision of behavioral health care for the Plan's enrollees.
4. The Plan fails to ensure USBHP's post-stabilization care process meets Knox-Keene Act requirements.
5. The Plan fails to ensure USBHP consistently and adequately monitors trends in over and under-utilization of behavioral health care services.
6. The Plan fails to ensure USBHP is consistently and adequately considering all issues within enrollee grievances and providing rectification when appropriate.

[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.

7. The Plan fails to ensure USBHP's customer service staff consistently identify enrollee expressions of dissatisfaction as grievances.
8. The Plan's website does not include information about accessing behavioral health care services and other Knox-Keene Act required information and fails to include a link to USBHP's website.
9. The Plan fails to ensure USBHP's customer service staff are knowledgeable and competent regarding enrollee questions and concerns.
10. The Plan is acting at variance with its filed delegation agreements by failing to conduct adequate oversight of the behavioral health functions delegated to USBHP.
11. The Plan failed to file its On-going Delegation Oversight policy and procedure with the Department.

Additionally, the Department identified the following five barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, Grievances and Appeals, and Enrollee and Provider Experience:

1. Neither the Plan nor USBHP review Independent Medical Review (IMR) overturn data to track whether denials are creating unnecessary barriers for access to behavioral health care.
2. USBHP does not track all Single Case Agreements (SCA) requests to identify potential gaps in network coverage.
3. USBHP does not track and trend repeat callers to identify patterns and problems that enrollees may experience in accessing behavioral health care.
4. USBHP's standard fee schedule may create a barrier to increasing and retaining the number of in-network behavioral health care providers sufficient to meet the needs of the Plan's enrollees.
5. Pre-payment and post-payment audits by USBHP's Payment Network Integrity (PNI) unit may discourage providers from accepting Plan enrollees.

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 violations. 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 medical 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 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 June 1, 2022 through May 31, 2024, the Department requested and reviewed plan documents, files,

[3] Rule 1300.67.2.2(c)(1).
[4] Rule 1300.67.2.2(c)(2).
[5] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated products.

and data, and conducted interviews with Plan and behavioral health delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

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

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department contacted stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the Department's Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan BHI, the Department contacted eight enrollees and three providers whose input was considered for the Plan's BHI. The interviews were conducted between January 2024 and March 2024. The three providers serviced Los Angeles and San Diego counties. The issues raised by interviewed enrollees included lack of in-network provider available within geographic and timely access and failure on the part of USBHP to refer and/or authorize out-of-network services. The enrollees resided or worked in Contra Costa, San Bernadino, San Diego, San Francisco, San Luis Obispo, and Sonoma Counties.

PLAN BACKGROUND

UnitedHealthCare of California obtained its Knox-Keene license in 1978 and is headquartered in Cypress, CA. The Plan is a full-service health care service plan licensed to provide health care services to small group, large group and Medicare members. The managed care plans include a health maintenance organization product. As of September 30, 2025, the Plan had 378,352[6] enrollees in its commercial lines of business. The Plan operates in Alameda, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Merced, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura and Yolo counties.

[6] Source: DMHC Dashboard [2025 Q3]

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan fails to ensure USBHP consistently identifies, investigates and documents potential provider directory inaccuracies reported to USBHP's customer service and grievance departments.

Statutory/Regulatory References: Section 1367.27(e)(1), 1367.27(j)(3), 1367.27(o)(1), 1367.27(o)(2)(B) and 1367.27(n)(2)

Supporting Documentation:

- *Amendment Twenty-Three to the Behavioral Health Services Agreement between U.S. Behavioral health Plan and UHC of California* (Delegation Agreement) (Effective Date: July 1, 2016)
- USBHP *Provider Directory Development, Data Verification and Maintenance* Policy (Last Update: December 2023)
- USBHP *Resolution of Enrollee Grievances Policy* (Last Update: December 2023)
- 21 USBHP Enrollee Call Inquiry Files (June 1, 2022 through May 31, 2024)
- 20 USBHP Standard Grievance Files (June 1, 2022 through May 31, 2024)

Assessment: Health plans are required to promptly investigate a reported inaccuracy of information in the provider directory or directories, 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, health plans must document the receipt and outcome of each reported inaccuracy, including any updates or changes made to its directory or directories.[8] These provider directory requirements are not waived if delegated by the Plan. [9]

In addition, plans are required to update their online provider directory, at least weekly, when a change is necessary after the completion of an investigation based on an enrollee complaint that a provider was not accepting new patients, was otherwise unavailable, or whose contact information was listed incorrectly.[10] A plan is further required to remove a provider from the directory when a provider retires or ceases to practice, a provider or provider group is no longer under contract with the plan, or when a contracting provider group is no longer associated with the provider group.

Per the Delegation Agreement, USBHP is delegated all provider directory functions, including, but not limited to, maintaining and updating its online provider directory. With respect to the Plan's oversight of delegated functions, the Delegation Agreement states the Plan "shall remain liable for its compliance with Section 1367.27, and responsible for monitoring and oversight of Vendor's [USBHP] responsibilities for network and provider

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

directory."[11] Therefore, the Plan was obligated to ensure USBHP was identifying, documenting and investigating reports of provider directory inaccuracies.

Plan Documents

The Department requested the Plan provide its policies and procedures describing any delegation oversight processes of quality assurance, utilization management and/or grievance and appeals to ensure consistent, effective, and appropriate oversight of these functions.[12] The Plan provided its *On-going Delegation Oversight* procedure, which states the Plan's "Clinical Delegation Oversight Team provides on-going monitoring of all aspects of Delegate responsibilities, and adherence to contractual relationships."[13] The procedure is not specific to USBHP, but to "delegates" in general. The procedure states in the "Regulatory Oversight" section the Plan conducts quarterly assessments and comprehensive annual assessments of the performance of delegated functions by the delegate.

USBHP Documents

USBHP's *Provider Directory Development, Data Verification and Maintenance Policy* describes USBHP's process for receiving and investigating reported provider directory inaccuracies. It states that enrollees, potential enrollees, providers, USBHP staff or members of the public may report provider directory inaccuracies either through a link on USBHP's online provider directory or by calling USBHP's main customer service line.[14]

The policy further states upon receipt of a report that USBHP's provider directory contains an inaccuracy, USBHP "promptly investigates the reported inaccuracy and, no later than 30 business days following receipt of the report, verifies the accuracy of the information or updates the information in the directory, as applicable, and undertakes corrective action if necessary."[15] If USBHP finds that changes are needed to its provider directory, USBHP submits a data maintenance request (DMR) to USBHP's provider directory database. Then, according to the policy, a provider directory database specialist should make the changes necessary to the provider directory.

The policy also states reports of potential provider directory inaccuracies received from Plan enrollees are incorporated into USBHP's grievance system by screening the reports to identify whether the reported issue meets the definition of a grievance as defined by Section 1300.68(a)(1). As an example, if the enrollee reasonably relied upon USBHP's provider directory and experienced an "adverse event," such as paying out-of-pocket for covered behavioral health care services, then that report would be escalated to a grievance.[16]

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[11] *Amendment Twenty-Three to the Behavioral Health Services Agreement between U.S. Behavioral health Pan and UHC of California* (Delegation Agreement) (Effective Date: July 1, 2016), page 1.
[12] Crosswalk Request BHIQA4
[13] BHIQA_On-Going Delegation Oversight, page 1.
[14] USBHP *Provider Directory Development, Data Verification and Maintenance* Policy (Last Update: December 2023), page 6.
[15] Id.
[16] Id.

USBHP's *Resolution of Enrollee Grievances Policy* also states reports of potential provider directory inaccuracies received from enrollees are screened to identify whether the issue meets the definition of the grievance. The policy further states if an enrollee reasonably relies on inaccurate, incomplete, or misleading information in USBHP's provider directory, USBHP will provide coverage for all services provided to the enrollee that resulted from the enrollee's reliance on the inaccurate information.[17] The policy does not describe how the grievance staff would document, report or investigate the reported inaccuracy itself.

Interviews

During interviews, USBHP was asked what Customer Services Representatives (CSRs) consider a provider directory inaccuracy. The CSR responded they are trained for provider directory inaccuracy reporting, which include a provider not accepting new patients or any change to the provider's information. The CSR reported they receive between one to two reports of provider directory inaccuracies per week.

File Review

The Department reviewed 21 USBHP enrollee inquiry files and audio recordings and determined 15 files (71%)[18] were related to difficulty finding an available provider through the Plan's directory either because the provider was not taking new patients, the provider did not accept the Plan or a search by USBHP found no available appointments. In six (40%)[19] of the 15 files, the caller informed the USBHP representative of a potential directory inaccuracy and there was no documentation that the potential inaccuracy was referred, investigated, or reported for further determination and potential correction as warranted. Additionally, there was no documentation in the files indicating whether the reported provider directory issues were screened to determine if the report met the definition of a grievance, as described in USBHP's *Provider Directory Development, Data Verification and Maintenance Policy*.

The Department also reviewed 20 USBHP standard grievance files and determined two files (10%)[20] involved reported provider directory inaccuracies and in both files (100%), the reported provider directory inaccuracy was not referred, investigated, or reported.

Case Examples

- **LFC File #9:** The enrollee's parent called USBHP to follow-up on a request for a single case agreement (SCA) which had been denied. The CSR advised that USBHP would find an in-network provider and the enrollee's parent stated that USBHP had previously provided names of two providers; however, one was a work colleague of the enrollee's mother, and the other was not accepting new patients, which was not reflected in the provider directory. The call was escalated to a supervisor but there were no additional notes in the file to indicate how the call was resolved with the supervisor. Despite the enrollee

[17] USBHP *Resolution of Enrollee Grievances Policy* (Last Update: December 2023), page 7.
[18] LFC File #2, #4, #6, #7, #8, #9, #10, #12, #13, #15, #16, #17, #19, #20 and #21
[19] LFC File #2, #9, #12, #13, #15 and #19.
[20] LFF File #32 and #38.

informing USBHP about a provider directory inaccuracy, there is no evidence that the reported directory inaccuracy was identified, documented, or investigated. Further, there is no evidence in the file demonstrating the CSR screened the call to determine if the reported provider directory inaccuracy should be treated as a grievance.

- **LFF File #32:** The enrollee called USBHP expressing frustration with finding an available in-network provider. The enrollee stated the list of providers given to them by USBHP from the provider directory were not accepting new patients. The enrollee also stated one provider scheduled an intake appointment for the enrollee and subsequently advised their practice was full. The grievance resolution letter indicated USBHP conducted a quality of service investigation but there was no evidence that the reported provider directory inaccuracy was identified, referred, or investigated.

Conclusion: Plan and USBHP documents, call inquiry files, and grievance files, demonstrated that enrollee reports of potential provider directory inaccuracies to USBHP's CSRs and grievance unit staff are not consistently documented, investigated and/or corrected in USBHP's provider directory database. Furthermore, the issues are not consistently documented, reported, investigated or incorporated into the grievance system. The Plan is failing to ensure USBHP is complying with provider directory requirements and, therefore, the Department finds the Plan in violation of Sections 1367.27(e)(1), 1367.27(j)(3), 1367.27(o)(1), 1367.2(o)(2)(B), and 1367.27(n)(2).

#2: The Plan fails to ensure USBHP consistently offers enrollees behavioral health appointments within the timely access standards when they call or submit grievances about requesting behavioral health appointments.

Statutory and Regulatory References: Sections 1367.03(a)(1), (a)(5)(D) and (E) and (c), 1368(a)(1) and (4) and Rule 1300.67.2.2(b)(2), and (c)(5)(D) and (E)

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.*[21] (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement between PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)
- Plan's *On-going Delegation Oversight Procedure* (September 7, 2022)
- USBHP *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours* (QIC Approved: December 2023)
- USBHP *Resolution of Enrollee Grievances* (Last Update: December 2023)

[21] UHC of California, formerly PacifiCare of California, and USBHP, formerly PacifiCare Behavioral Health of California, Inc (PBHC). On July 1, 2010, PBHC and USBHP legally merged with USBHP being the sole surviving entity of that merger (Efiling # 20092483 and 20092486). In 2005, UnitedHealth Group purchased PacifiCare of California, Inc, and in 2011, the Department approved a notice of material modification proposing a corporate name change from PacifiCare of California to UHC of California. (Efiling #20102306)

- USBHP *Participating and Non-Participating Clinician and Facility Referrals* (QIC Approved December 2024)
- 21 USBHP Enrollee Call Inquiry Files (June 1, 2022 through May 31, 2024)
- 31 USBHP Repeat Caller Inquiry Files (June 1, 2022 through May 31, 2024)
- 20 USBHP Standard Grievance Files (June 1, 2022 through May 31, 2024)

Assessment: Plan grievance systems must have reasonable procedures to ensure that enrollee grievances are adequately considered and rectified when appropriate.[22] 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.[23] 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.[24]

When an enrollee requests a behavioral health appointment, the Plan is required to offer appointments within specified timely access standards, with limited exceptions.[25] The timeframe for appointments depends on the urgency of the service requested and the type of service.[26] Nonurgent appointments with a nonphysician mental health provider must be offered within 10 business days of the request, and nonurgent appointments with specialty care physicians within 15 business days of the request.[27] 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. [28] 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.[29]

When an enrollee calls a health plan and requests an appointment or assistance with scheduling an appointment, the health plan is required to offer an appointment within applicable timely access standards. Also, 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 may consider the expression as an initial request for an appointment. Adequate consideration and resolution of enrollee grievances involving a delay or difficulty obtaining a behavioral health appointment require offering the enrollee an appointment within timeliness standards.

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[22] Section 1368(a)(1)
[23] Rule 1300.68(a)(4)
[24] Section 1368(a)(1); Rule 1300.67.2.2(b)(2)
[25] 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).).
[26] Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5)
[27] Section 1367.03(a)(1); Rule 1300.67.2.2(c)(5)(D) and (E)
[28] Section 1367.03(a)(5)(A) and (B)
[29] Section 1367.03(a)(5)(F)

The obligation of a plan to ensure compliance with timeliness standards is not waived if the plan delegates services or activities to any contracting entity or provider group.[30] Per Exhibit C of the Master Agreement, the Plan delegated all behavioral health grievance functions to USBHP.[31] With respect to the Plan's oversight of delegated functions, the Master Agreement further states that the Plan shall "monitor the performance of duties delegated to PBHC [USBHP] under this Agreement to ensure compliance by PBHC [USBHP] with California laws and regulations."[32] Although Amendment Six to the Master Agreement updated and replaced Exhibit C, grievance functions remain delegated to USBHP.[33] Therefore, the Plan was obligated to oversee USBHP processes to ensure USBHP offered behavioral health appointments within timely access standards.

Plan Documents

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

USBHP Documents

USBHP's *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours*[34] policy defines the scripted intake process for non-licensed customer service staff to follow during normal business hours. The policy describes that a non-licensed staff triages the call based on the enrollee's responses to USBHP's pre-determined script and describes how to handle certain enrollee calls. The policy states, for "situations in which the call is for a routine referral and the enrollee has not identified a clinician, non-licensed staff check the electronic care management system for in-network referrals." The non-licensed staff offers names of in-network providers that match the enrollee's geographic area and other preferences and informs the enrollee that in-network providers are expected to "offer an appointment within ten (10) business days." The policy says the non-clinician can issue an authorization or referral for routine outpatient treatment if requested. Lastly, the policy states that in "the event there are no appropriate contracted clinicians in the enrollee's geographic area, non-licensed staff submit an accommodation request on behalf of the enrollee."

USBHP's *Resolution of Enrollee Grievances* policy describes USBHP's process for investigating and resolving enrollee grievances. The policy identifies broad categories of issues that are handled as grievances, such as quality of care, clinical, and reports of provider directory inaccuracies, but does not describe how USBHP's grievance system should process grievances involving a delay or difficulty in obtaining an appointment for covered behavioral health care services.

[30] Section 1367.03(c)
[31] *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.*[31] (Master Agreement) (Effective July 1, 2000), page 43.
[32] Id., page 20.
[33] *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (August 1, 2004), page 14.
[34] Crosswalk Request BHICS7_Call_Triage

File Review

USBHP's call inquiry files demonstrated that when enrollees called USBHP expressing difficulty finding an in-network provider and/or obtaining a behavioral health appointment, USBHP did not consistently offer the enrollee an appointment or refer the enrollee to an in-network provider as described in the *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours* policy. The Department reviewed 20 call inquiry files and found that in 19[35] (95%) files the enrollee was calling for assistance in locating an in-network provider and/or scheduling an appointment. In four[36] (21%) files USBHP failed to demonstrate that the enrollee was referred to an in-network provider or offered an appointment within timely access standards. The Department reviewed 31 repeat call inquiry files and found that in 14[37] (45%) files the enrollee was calling for assistance in locating an in-network provider and/or scheduling an appointment. In 8[38] (57%) files USBHP failed to demonstrate that the enrollee was referred to an in-network provider or offered an appointment within timely access standards.

USBHP's grievance files demonstrated that when enrollees called USBHP expressing difficulty obtaining a behavioral health appointment, USBHP did not consistently offer the enrollee an appointment within timely access standards. Review of USBHP's grievance case files demonstrated that USBHP's process for enrollees with difficulty accessing behavioral health appointments is to open a standard grievance and assign the enrollee a care advocate. The Department reviewed 20 standard USBHP grievance and appeals files.[39] The Department found 10[40] (50%) files involved enrollees expressing a delay or difficulty in obtaining a timely behavioral health appointment. In eight (40%) files[41], USBHP failed to demonstrate that the enrollee was offered an appointment within timely access standards.

Table 1

Call Inquiry and Grievance and Appeals File Review

FILE TYPE	NUMBER OF FILES	LEGAL REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiries	19	Plan offers behavioral health appointments in compliance with timely access standards	15 (79%)	4 (21%)
Repeat Caller Inquiries	14	Plan offers behavioral health appointments in compliance with timely access standards	6 (43%)	8 (57%)
Standard Grievance and Appeals	10	Plan offers behavioral health appointments in compliance with timely access standards	2 (20%)	8 (80%)

[35] LFC File #1-10 and #12-21
[36] LFC File #9, #12, #13 and #15
[37] LFC_RP File #3, #5, #9, #10-17 and #19-21
[38] LFC_RP #5, #12, #13, #17, #18, #19, #20 and #21
[39] LFF Files #21-40
[40] LFF File #: 26-30, #32, #34-36 and #38
[41] LFF File: #26, #29, #30, #32, #34, #35, #36 and #38

Case Examples:

- **LFC File #15**: On October 11, 2023, the enrollee's mother called USBHP for assistance in locating an available in-network therapist specializing in Eye Movement Desensitization and Reprocessing (EMDR). The mother informed the CSR she called providers in USBHP's directory and none are taking new patients. The mother identified an out-of-network provider with openings, but the CSR informed her they do not have out-of-network benefits. The CSR did not submit a referral to an in-network provider, nor did the CSR identify any in-network providers specializing in EDMR with appointments available within geographic and timely access standards.

  Nonurgent appointments with a nonphysician mental health or substance use disorder provider are required to be offered within 10 business days of the request.[42] In this case, there is no evidence that USBHP referred the enrollee to an in-network provider or offered an appointment with an in-network provider within timely access standards.

- **LFC_RP File # 17, 18 and 19:** On July 29, 2022, the enrollee called USBHP for assistance in locating an in-network psychiatrist. The enrollee informed the CSR it took them a long time to identify what they thought was an in-network psychiatrist, but on their first visit the psychiatrist told the enrollee they are not in-network. The CSR offered to have the Centralized Appointment Search Team (CAST)[43] assist with finding a provider.[44] On August 2, 2022, a CSR called back to inform the enrollee they were assigned to the CAST search and will call back when they find an available provider.[45] On August 2, 2022, the CSR called the enrollee again and left a voicemail stating they found one provider with an in-person appointment on August 31, 2022.[46]

  Nonurgent appointments with behavioral health specialists are required to be offered within 15 business days of the request.[47] In this case, USBHP offered the enrollee an appointment with an in-network behavioral health specialist on August 31, 2022, 23 business days after the request.

- **LFF File #26:** On June 30, 2023, the enrollee filed a grievance with USBHP regarding difficulty obtaining an appointment with a behavioral health specialist. Although the enrollee located one in-network provider, that provider asked the enrollee to pay out-of-pocket for the covered behavioral health care services. The case file notes indicated USBHP focused its grievance investigation on the in-network provider charging the enrollee out-of-pocket and not on assisting the

[42] Section 1367.03(a)(5)(E); Rule 1300.67.2.2(c)(5)(E)
[43] The Department requested a job aid or policy describing the Plan's CAST process in On-Site Additional Document Request #56. The Plan provided a job aid that states CAST is a team of care advocates that completes requests for appointment searches with in-network providers. If the CAST team finds an appointment with an in-network provider, the care advocate will call the enrollee with the appointment information.
[44] LFC_RP File #17
[45] LFC_RP File #18
[46] LFC_RP File #19
[47] Section 1367.03(a)(5)(D); Rule 1300.67.2.2(c)(5)(D)

enrollee in obtaining an appointment with an in-network provider. The grievance resolution letter dated July 28, 2023, stated, among other things, the enrollee's issue of difficulty locating in-network providers was forwarded to USBHP's provider relations team to "address any shortcomings in our referral process," but did not address finding an in-network provider. USBHP's provider relations team is not involved in assisting enrollees to find available in-network providers.

Nonurgent appointments with behavioral health specialists are required to be offered within 15 business days of the request.[48] In this case, the grievance resolution letter, sent 20 business days after the enrollee filed their grievance, failed to identify any available in-network providers and there was no evidence in the file demonstrating the enrollee was offered an appointment within timely access standards.

- **LFF File #29:** On November 14, 2022, the enrollee emailed the Plan regarding difficulty finding an in-network therapist. On November 16, 2022, the Plan forwarded the enrollee's complaint to USBHP and USBHP's Care Advocacy Department was notified of the grievance so they could assist the enrollee in finding an in-network provider. The case file notes reflect that a care advocate planned outreach to the enrollee on November 29, 2022, 15 days after the enrollee had submitted a grievance. The care advocate noted, "We will expedite the [appointment] search as best we can." The grievance resolution letter dated December 2, 2022, stated, among other things, "Please note the Care Advocacy Department is actively searching for an available in-network provider for [your child]."

  Nonurgent appointments with a nonphysician mental health or substance use disorder provider are required to be offered within 10 business days of the request.[49] In this case, the grievance resolution letter, sent 13 business days after the enrollee filed their grievance expressing difficulty in finding an in-network provider, indicated USBHP was still searching for an in-network provider. There was no evidence in the file demonstrating the enrollee was offered an appointment within timely access standards.

- **LFF File #35:** On August 5, 2022, the enrollee filed a grievance with USBHP regarding difficulty finding a psychiatrist. The case file notes indicated the enrollee had previously communicated with USBHP on March 29, April 6, April 15, and July 8, 2022, for assistance in locating an in-network psychiatrist. On August 26, 2022, three weeks after the initial grievance filing, a USBHP care advocate left a voicemail for the enrollee to assist in locating an in-network provider. The case resolution summary notes dated August 31, 2022, indicated the enrollee was provided lists of in-network psychiatrists on April 6 and July 9, 2022, but the enrollee made no follow-up calls to USBHP to inform USBHP that the "list(s) did not work," and as a result, the grievance was closed as "unsubstantiated." The grievance resolution letter dated August 31, 2022, stated the enrollee was

[48] Section 1367.03(a)(5)(D); Rule 1300.67.2.2(c)(5)(D)
[49] Section 1367.03(a)(5)(E); Rule 1300.67.2.2(c)(5)(E)

provided lists of in-network providers on April 6 and July 9, 2022, and that they had been assigned a care advocate.

Nonurgent appointments with behavioral health specialists are required to be offered within 15 business days of the request.[50] In this case, the grievance resolution letter, sent 19 business days after the enrollee filed their grievance, failed to identify any available in-network providers and there was no evidence in the file demonstrating the enrollee was offered an appointment within timely access standards.

Interviews

During interviews, a USBHP representative stated USBHP had a process that occurred outside of, and in tandem with, the grievance investigation to ensure timely appointments for enrollees that had filed a grievance related to difficulty obtaining an appointment. In response, the Department requested USBHP provide policies and procedures supporting this process along with examples of this process in practice for 10 standard grievance files involving enrollees expressing difficulty obtaining a behavioral health appointment. In response, USBHP provided examples of CAST search results for those grievance files[51] and a policy document titled *Participating and Non-Participating Clinician and Facility Referrals* that states in the event the enrollee is unable to secure an appointment, USBHP's personnel will intervene by "securing an appointment for the enrollee." However, this document does not specifically address the grievance process, or how the enrollee is offered an appointment as part of the grievance process or outside of it. The CAST search results examples USBHP provided for the grievance files identifies providers by name, phone number and license and indicates that USBHP provided the lists to enrollees by email or verbally over the phone. They do not document whether the enrollee received an appointment from any of the identified providers, or whether the enrollee was offered an appointment.

USBHP's *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours* procedure describes multiple ways a CSR can offer the Plan's enrollees an appointment within timely access standards, such as referring the Plan's enrollees to in-network providers, authorizing routine outpatient services, and identifying in-network providers with timely appointments. However, review of case files revealed that USBHP is failing to consistently offer enrollees appointments within timely access standards.

Although the Master Agreement, Amendment Six and the *On-going Delegation Oversight* procedure included provisions requiring the Plan to monitor and evaluate USBHP's compliance with delegated functions, such as grievances and timely access to care, the Plan did not monitor or evaluate care advocate calls, grievance investigations, or CAST search results to ensure enrollees were offered appointments withing timely access standards.

Conclusion: Plan and USBHP documents, call inquiry and grievance files demonstrated USBHP's processes fail to ensure enrollees are consistently offered appointments within timely access standards. The Plan is failing to ensure USBHP is complying with timely

[50] Section 1367.03(a)(5)(D); Rule 1300.67.2.2(c)(5)(D)
[51] LFF File #26, #29, #30, #32, #34, #35, #36 and #38

access requirements and, therefore, the Department finds the Plan in violation of Sections 1367.03(a)(1), and (a)(5)(D), (E), 1368(a)(1) and (4), and Rule 1300.67.2.2(b)(2), and (c)(5)(D) and (E).

#3. <u>The Plan fails to ensure USBHP consistently arranges for the timely provision of behavioral health care for the Plan's enrollees.</u>

Statutory and Regulatory References: Sections 1367(d), 1367.03(a)(1), and (a)(5)(A), (B), (C), (D), (E) (F) and (7)(C), 1367.03(c), 1374.72(a)(1) and (d), 1374.721(f)(3)(A) and Rule 1300.67.2.2(c)(1)

Supporting Documents:

- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)
- *Amendment Twenty-Seven to the Behavioral Health Services Agreement between UHC of California and U.S. Behavioral Health Plan* (SB 855 Agreement Amendment) (Effective January 1, 2021)
- Plan's *On-going Delegation Oversight Procedure* (September 7, 2022)
- USBHP *Initial Authorization for Behavioral Health Services* (QIC Approved March 2024)
- USBHP *Participating and Non-Participating Clinician and Facility Referrals* policy (QIC Approved December 2023)
- 20 Urgent Grievance Files (June 1, 2022 through May 31, 2024)
- 15 USBHP Benefit Coverage Denial Files (June 1, 2022 through May 31, 2024)

Assessment: Health plans are required to provide coverage for all medically necessary behavioral health care services and shall furnish services in a manner providing continuity of care and ready referral of enrollees to other providers when appropriate.[52] A request for utilization review of a behavioral health care service may originate from a provider, enrollee, or their authorized representative.[53] Health plans shall 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.[54] If behavioral health services are not available within geographic and timely access standards, then health plans shall arrange coverage to ensure the delivery of medically necessary out-of-network services.[55]

The obligation of a plan to ensure compliance with timeliness and geographic access standards is not waived if the plan delegates services or activities to any contracting entity or provider group. [56] Per the SB 855 Agreement Amendment, USBHP is delegated all SB 855 compliance functions.[57] With respect to the Plan's oversight of delegated

[52] Sections 1367(d) and 1374.72(a)(1)
[53] Section 1374.721(f)(3)(A)
[54] Section 1367.03(a)(1) and (a)(5)(A)(B)(C)(D) and (E)
[55] Section 1367.03(a)(7)(C) and 1374.72(d)
[56] Section 1367.03(c)
[57] *Amendment Twenty-Seven to the Behavioral Health Services Agreement between UHC of California and U.S. Behavioral Health Plan* (SB 855 Agreement Amendment) (Effective January 1, 2021), page 1.

functions, the SB 855 Agreement Amendment states "United confirms that its oversight and monitoring obligations as set forth in Section 3.12 of the Agreement and by Exhibit C Delegation Standards and Oversight, as amended by Amendment Number Six to the Agreement, extend to the requirements set forth in this Amendment".[58] Therefore, although the Plan delegated behavioral health services to USBHP, ensuring compliance with timely and geographic access standards remained the Plan's responsibility, including referring enrollees to out-of-network providers when in-network services were not available within those standards.

The Department's investigation revealed that USBHP has a practice of administratively denying requests for out-of-network services without offering, referring or authorizing in-network services within geographic and timely access standards.

Plan Documents

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

USBHP Documents

The Department requested the Plan explain how USBHP arranges coverage for out-of-network services when a behavioral health service is not available in-network within geographic and timely access standards.[59] In response to the Department's request, USBHP provided a narrative that stated, if behavioral health services are not available in-network within the geographic and timely access standards set by law or regulation, USBHP shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. USBHP also stated the enrollee shall pay no more than the same cost sharing the enrollee would pay for the same covered services received from an in-network provider.[60]

USBHP's *Participating and Non-Participating Clinician and Facility Referrals* policy[61] states that USBHP personnel refer enrollees to participating providers for inpatient and outpatient behavioral health services whenever possible (except for emergency services that do not require prior authorization). The policy describes that in the event the enrollee/caller is unable to secure an appointment with a participating clinician, USBHP intervenes by securing an appointment for the enrollee. "The policy also states that "authorization to a non-participating clinician or facility may be considered for enrollees under certain circumstances."[62] The policy states if services for medically necessary treatment of mental health or substance use disorder are not available within the geographic and timely access standards, USBHP shall arrange for coverage to ensure delivery of medically necessary out-of-network services.

[58] Id., page 3.
[59] Response to Crosswalk Request BHIAA_NC6
[60] Id.
[61] BHIAA_NC6_Par_NonPar_Refrl.pdf (eFiling # 20230827, Date Filed: 6/26/2023, Date Filing Closed: 9/12/2023), page 1.
[62] Id. page 3.

USBHP's *Initial Authorization for Behavioral Health Services*[63] states that pre-authorization requests may be received from enrollees, employee assistance program representatives, clinicians/facilities, a clinician acting on behalf of the enrollee, family members or other Authorized Member Representatives. The policy also states that for calls to request Facility Based Care services, a care advocate gathers "only the critical information needed," to make a clinical determination.

File Review

The Department reviewed 20 urgent USBHP grievance and appeal files. In the three (15%) urgent grievance and appeal files[64] detailed below, the enrollees, were denied treatment with an out-of-network provider on the grounds they did not have out-of-network benefits. In all three files (100%), the types of services requested were subject to pre-authorization whether the services were provided by an in or out-of-network provider and USBHP failed to offer, refer or authorize the requested services in-network within timely and geographic access.

The Department also reviewed a random sample of 15 USBHP benefit coverage denial files. In seven (47%) files,[65] USBHP administratively denied requests from out-of-network providers and failed to offer, refer, or authorize the requested services with an in-network provider within geographic and timely access. In all eight files (100%), the requested service required prior authorization regardless of whether the treating provider was in-network or out-of-network.

Contrary to the *Participating and Non-Participating Clinician and Facility Referrals* policy, the urgent appeals of authorization denials and the benefit coverage denials case files were all processed as administrative denials, with no clinical review to determine if the requested out-of-network services were medically necessary. Furthermore, there was no evidence that USBHP offered, referred or authorized the enrollee to receive treatment from an in or out-of-network provider within the timely and geographic access standards.

Case Examples:

- **LFF File #11:** An adolescent enrollee's out-of-network residential treatment center (RTC) filed an urgent appeal with USBHP for a denied authorization request for a single-case agreement (SCA). The out-of-network RTC specialized in trauma-focused care for women under age 21. The enrollee and her family specifically wanted treatment at an all-female facility. USBHP's internal notes stated that "a facility search found six available INN facilities, including one with an all-female unit, within geo-access." A USBHP medical director denied the request without any evidence of conducting a clinical review, citing an EOC provision that stated out-of-network services are not covered unless authorized, emergent, or out-of-area urgent services. The case file did not contain any evidence that the one in-network provider identified had any openings, or whether the enrollee was

[63] BHIUM1_InitialAuthBHSrvc.pdf
[64] LFF Urgent Grievance File #11, #17 and #19
[65] LFB_BH #2, #3, #5, #9, #12, #13 and #15

referred or authorized to receive treatment from the in-network provider within geographic and timely access standards.

- **LFF File #17**: An adolescent enrollee's out-of-network provider filed an urgent appeal requesting an SCA with USBHP to provide intensive outpatient (IOP) services to treat the enrollee's substance use disorder. The provider informed USBHP the enrollee was already receiving IOP services from the provider when the enrollee became a Plan member.[66] The provider stated the in-network providers on the list given to the enrollee prior to filing the urgent appeal were not child or adolescent certified and were not geographically accessible. USBHP's appeals specialist denied the request without conducting any clinical review and USBHP did not assist the enrollee in finding an in-network provider nor did USBHP refer the enrollee to an in-network provider within geographic and timely access standards.

- **LFF File #19**: An out-of-network provider filed an urgent appeal of a denial for RTC services. The provider requested an urgent appeal on the basis that there was no clinical review done of the enrollee's specific condition. On appeal, USBHP declined the provider's request for a peer review and a care advocate administratively denied the request without conducting a clinical review. The denial letter cited an EOC provision that stated out-of-network services are not covered unless authorized, emergent, or out-of-area urgent services. The case file did not contain any documentation whether in-network services were available within geographic and timely access standards, or that the enrollee was referred or authorized to receive RTC services from an in-network provider.

- **LFB BH File #5**: An out-of-network provider called USBHP requesting authorization of RTC services for one of the Plan's adolescent enrollees. The file notes indicate USBHP identified an in-network provider with openings that provides adolescent RTC services, but there was no evidence in the file that USBHP referred or authorized the enrollee to receive RTC services from the in-network facility. The denial letter stated services from out-of-network providers without authorization are not covered and that "in network providers are available to provide treatment" without identifying any in-network provider. This file demonstrates that USBHP administratively denied out-of-network services and failed to offer, refer, or authorize in-network services within geographic and timely access standards.

- **LFB BH File #13:** An out-of-network provider called USBHP requesting authorization of IOP services for one of the Plan's enrollees. The out-of-network facility stated there were no available in-network facilities within geographic access standards. The file notes indicate USBHP identified one in-network provider with openings, but there was no indication whether the provider was within geographic access of the enrollee. There was also no evidence in the file that USBHP referred or authorized the enrollee to receive IOP services from the in-network facility. The denial letter stated services from out-of-network providers

[66] For clarity, all enrollees are members of the Plan, but USBHP is delegated the responsibility to provide behavioral health benefits.

without authorization are not covered and that "in network providers are available to provide treatment" without identifying any in-network providers. This file demonstrates that USBHP administratively denied out-of-network services and failed to offer, refer, or authorize in-network services within geographic and timely access standards.

The above files demonstrate that when out-of-network providers request authorization on behalf of Plan enrollees, the requests are administratively denied on the basis there is no coverage for out-of-network services. Further, although USBHP may identify in-network providers, there was no evidence USBHP determined they met timely and geographic access standards and that USBHP referred or authorized the enrollees to see those in-network providers. During interviews, the Department asked why the service requests that were the subject of the urgent appeal files were not reviewed to determine if the care was medically necessary, whether provided in or out-of-network. USBHP responded that these were administrative denials because the enrollees did not have out-of-network benefits. In other words, USBHP acknowledged it does not review requests for out-of-network services for medical necessity even if the requested services required prior authorization to see a network provider. USBHP also administratively denied out-of-network services without first ensuring medically necessary in-network services are available within timely and geographic access standards.

Conclusion: Plan and USBHP documents, benefit coverage denial files, urgent appeal files and interviews demonstrated USBHP administratively denied out-of-network care and failed to offer, refer, or authorize the enrollee to receive in-network services within geographic and timely access standards. The Plan is failing to ensure USBHP is complying with timely access and SB 855 requirements and, therefore, the Department finds the Plan in violation of Sections 1367(d), 1367.03(a)(1) and (5)(A) – (F), 1367.03(c), 1374.72(a)(1) and (d), 1374.721(f)(3)(A) and Rule 1300.67.2.2(c)(1).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#4: **The Plan fails to ensure USBHP's post-stabilization care process meets Knox-Keene Act requirements.**

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

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- Plan's *On-going Delegation Oversight Procedure* (September 7, 2022)
- USBHP *Review and Handling of Emergency Service Claims* (QIC Approved December 2023)
- USBHP *Provision of Crisis Assessment/Emergency Services Policy* (QIC Approved December 2023)
- Sample Member Identification Card
- USBHP *Customer Service Triage Guide* (Undated)

- USBHP *AB 1203 Notice* (2023 & 2024)
- *Behavioral Health Levels of Care (LOC)* document[67] (Undated)
- USBHP 31 Repeat Caller Inquiry Files (June 1, 2022 through May 31, 2024)

Assessment: Health plans that require prior authorization for post-stabilization care are required to provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for post-stabilization care.[68] Health plans are required to provide all noncontracting hospitals in the state with specific plan contact information to facilitate this requirement no less than once a year.[69] They must also provide the same contact information to the Department to post on its public website.[70]

Health plans that are contacted by a contracting or noncontracting hospital must, within 30 minutes of the time the hospital makes the initial telephone call requesting authorization, either authorize post-stabilization care or disapprove the care and inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.[71] Health plans are prohibited from requiring a hospital representative or contracting clinician to make more than one call for the authorization of post-stabilization care.[72] If a plan fails to respond within 30 minutes of receipt of the initial call, the post-stabilization care is deemed to be authorized and the plan is required to pay for the care.[73]

Per Exhibit C of the Master Agreement, the Plan delegated all behavioral health utilization management functions to USBHP, which include post-stabilization care utilization management and the Knox-Keene Act required annual notices to non-contracting hospitals.[74]

Plan Documents

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

USBHP Documents

USBHP's *Review and Handling of Emergency Service Claims*[75] and *Provision of Crisis Assessment/Emergency Services Policy*[76] states USBHP "provides an authorization or non-coverage determination of medically necessity health care services after stabilization of a psychiatric emergency medical condition within one half hour of the request" from the treating facility. The policies state that if USBHP is unable "to make a

[67] Request #65 on Onsite Document Requests, submitted to the Plan on March 4, 2025.
[68] Section 1371.4(a) and 1262.8(i)
[69] Section 1262.8(j)
[70] Section 1262.8(k)
[71] Section 1371.4(j); Rule 1300.71.4(b)(1) and (c)
[72] Section 1371.4(j)(3)
[73] Section 1371.4(j)(2); Rule1300.71.4(b)(2)
[74] Behavioral *Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc*. (Master Agreement) (Effective July 1, 2000), pages 41-45.
[75] Response to Crosswalk BHIUM6_Rvw_Hndlng_ERClm.pdf submitted by Plan on September 17, 2024.
[76] Response to Crosswalk BHIUM5_ProvCrisisEmergSrvc.pdf.

decision to authorize or not cover" a post-stabilization authorization request within one half hour of the request, the care is deemed authorized. The policies also indicate if there is a disagreement between the treating hospital and USBHP regarding post-stabilization care, USBHP assumes responsibility for the care of the enrollee "by arranging, if necessary, for the transfer of the enrollee to another contracted facility." USBHP's *Provision of Crisis Assessment/Emergency Services Policy* describes USBHP's crisis line, which is staffed seven days a week, 24 hours a day by care advocates, who are licensed clinical personnel. This policy details that the care advocates handle authorization of post-stabilization requests from contracting and non-contracting hospitals.

The *AB 1203 Notice* is the annual notice USBHP sends to non-contracting hospitals identifying the phone number they should call to request authorization of post-stabilization care. USBHP's *AB 1203 Notice* issued during the BHI review period listed USBHP's main customer service number, rather than a direct number to a care advocate, to request authorization for post-stabilization care.[77]

Interviews

During interviews USBHP customer service staff indicated they were not familiar with post-stabilization care authorizations and that all requests for authorizations go to a care advocate. The customer service manager stated if the caller does not input their National Provider Identifier number (NPI), Provider Tax identification number, or member number in the automated voice system, they could end up connecting with the Plan's national team. The consequence of such a call being transferred to the Plan's national team could cause additional delays. If, for example, the caller is a non-contracting hospital attempting to obtain authorization of post-stabilization care and is transferred to a national team customer service agent, that agent would not be able to authorize post-stabilization care and would need to transfer the caller to a USBHP care advocate.

File Review

The Department reviewed 31 repeat call inquiry files[78] from USBHP's customer service line, which included 13[79] provider/facility inquiries and four[80] plan outreach calls. Three of the calls, discussed in detail below, involved one non-contracted provider's attempts to obtain authorization for post-stabilization care for one patient.

Case Examples

- **LFC_RP File #29, 30, and 31:** On July 22, 2022, at 2:33 p.m.,[81] a non-contracting hospital representative called USBHP after one of its enrollees was admitted inpatient after visiting the emergency room. The hospital representative stated

[77] USBHP's main customer service number, 1-800-999-9585, is the same number on the sample member ID card provided by the Plan (BHIAA_TA12), the AB 1203 Notice (BHIUM15_2023_AB1203_Notice), and on the Department's website: Plan Behavioral Health Crisis Post-Stabilization Authorization Telephone Number
[78] LFC_RP (repeat callers) Case Files
[79] LFC_RP Call Inquiry File: #2, #7, #8, #22, #23, and #25-31.
[80] LFC_RP Call Inquiry File: #33-36.
[81] LFC_RP Call Inquiry File: #29.

> they had been transferred "a few times" trying to reach someone to get authorization for post-stabilization care. The CSR stated they cannot give any information without a signed consent and advised they will contact a care advocate. The hospital representative was placed on hold for approximately 20 minutes and transferred to the care advocate. The care advocate informed the hospital representative to have a clinician from the hospital call back for precertification. The facility's utilization review nurse called back from the hospital at 5:07 p.m., again to address authorization for the enrollee and the USBHP CSR transferred the nurse to a care advocate.
>
> The Department researched claims data[82] submitted by the Plan to determine whether USBHP paid for the post-stabilization care provided to the Plan's enrollee in the above example. There were multiple claims for dates of service July 21 through July 29, 2022. The claim for the emergency services and care provided to the enrollee on July 21, 2022, was paid. However, the claims[83] for inpatient psychiatric services provided July 22 through July 29, 2022, were not paid. To further determine if USBHP paid or authorized the post-stabilization care, the Department searched USBHP's logs[84] for authorizations and found no authorizations for post-stabilization care for this enrollee.

The above example demonstrates USBHP failed to authorize the post-stabilization authorization request or inform the hospital that it will arrange for the prompt transfer of the enrollee to a contracted hospital within 30 minutes of the initial call. Therefore, the requested post-stabilization care should have been deemed approved and covered. However, review of USBHP's claims and authorization logs indicate USBHP failed to pay for the post-stabilization services provided. Furthermore, the hospital representative was instructed by USBHP to make more than one phone call in furtherance of the hospital's attempt to obtain authorization of post-stabilization care.[85]

The Department requested the Plan provide USBHP's desk top aid or workflow for the "Optum Care Advocate" team to follow when they receive a post- stabilization request.[86] USBHP provided the Level of Care Tool and *Customer Service Triage Guide*.[87] USBHP stated the customer service staff would utilize these documents to transfer such calls to the appropriate clinical team to identify the type of Level of Care being requested. USBHP also stated customer service staff have been trained on the Triage Guide "to determine how and where to properly triage such request to the appropriate clinical team to continue to manage such request for post-stabilization."[88] However, as the case example above demonstrated, USBHP's customer service staff failed to properly triage the post-stabilization authorization request and transfer to an appropriate clinical staff.

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[82] Log H Claims Data
[83] These claims identify the place of service as 051. According to the Centers for Medicare and Medicaid Services (CMS), place of service code 051 indicates an inpatient psychiatric facility.
[84] Logs A-1 and A-2
[85] The utilization management files reviewed by the Department did not include post-stabilization cases. Regardless, USBHP's intake process was flawed and the Plan is responsible for ensuring USBHP's process promotes Knox-Keene Act compliance.
[86] Document Request #67
[87] Id.
[88] Crosswalk Response to Request #65 on March 12, 2025.

This resulted in USBHP failing to either authorize within 30 minutes or arrange for the prompt transfer of the enrollee and forced the non-contracting hospital to call USBHP more than once.

The Plan is required to, within 30 minutes of the initial request for authorization of post-stabilization care, either authorize the care or inform the requesting hospital that it will arrange for the prompt transfer of the enrollee.[89] The Plan is prohibited from requiring the hospital to make more than one phone call to obtain authorization.[90] Failure to approve or disapprove a request for authorization of post-stabilization care within 30 minutes means the care is deemed authorized, and the Plan must pay for the medically necessary care.[91]

USBHP's process of having enrollees and hospitals contact its main customer service line rather than a dedicated line to obtain authorization for post-stabilization care can lead to confusion and is not conducive to USBHP responding timely to initial authorization requests, as demonstrated by inquiry calls. On the back end, it could lead to inappropriate denial of claims if initial calls by hospitals to USBHP's main customer service line and USBHP's responses are not appropriately documented, as demonstrated by USBHP's claims and authorization logs related to the above example.

Conclusion: Plan and USBHP documents and repeat caller files demonstrated that USBHP is failing to timely authorize post-stabilization care and is requiring hospitals to make more than one phone call to obtain authorization of post-stabilization care. The Plan is failing to ensure USBHP is complying with post-stabilization authorization requirements and, therefore, the Department finds the Plan in violation of Sections 1262.8(b)(2)(B), (d)(1)(A), (d)(1)(B), (d)(2), 1371.4(j)(1), (j)(2) and (j)(3), and Rule 1300.71.4(b)(1), (b)(2) and (c).

#5. <u>The Plan fails to ensure USBHP consistently and adequately monitors trends in over and under-utilization of behavioral health care services.</u>

Statutory/Regulatory Reference: Section 1367.01(j), Rule 1300.70(a)(1) and (3) and (c)

Supporting Documents:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (August 1, 2004)
- Plan's On-going Delegation Oversight Procedure (September 7, 2022)
- USBHP's *Quality Improvement and Utilization Management Programs* (2022 Evaluation)

[89] Sections 1262.8(d)(1)(A) and (B) and 1371.4(j)(1); Rule 1300.71.4(b)(1) and (2)
[90] Section 1371.4(j)(3) and 1262.8(b)(2)(B)
[91] Rule 1300.71.4(b)(2)

- USBHP's *Quality Improvement and Utilization Management Programs* (2023 Evaluation)

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.[92] Health plans' quality assurance programs are required to monitor whether the provision and utilization of services meet professionally recognized standards of practice.[93] Health plans must also implement procedures for continuously reviewing utilization of services and facilities.[94]

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.[95] 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.[96]

Per Exhibit C of the Master Agreement, the Plan delegated all behavioral health quality assurance functions, including quality management and improvement, and utilization functions to USBHP.

Plan Documents

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

USBHP Documents

USBHP's 2022 and 2023 *Quality Improvement and Utilization Management Programs* reports each include a section titled, "Ensuring Appropriate Utilization." This section includes data on Acute Inpatient Days/1000 enrollees, Inpatient Admits/1000 enrollees, Average Length of Stay, and Outpatient visits/1000 enrollees, compared across the past three years. The utility of the "Ensuring Appropriate Utilization," section is limited because USBHP 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 whether certain behavioral health care services are being over or under-utilized.

[92] Section 1367.01(j)
[93] Rule 1300.70(a)(3)
[94] Rule 1300.70(c)
[95] 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.
[96] Section 1367.01(j) and Rule 1300.70(a)(1), (3) and (c).

For example, the reports track the number of behavioral health outpatient visits per 1000 enrollees but do not capture what specific mental health services enrollees are accessing (i.e., substance use disorder, anxiety, depression, etc.).

The Department requested the Plan submit copies of policies and procedures pertaining to the identification, monitoring and handling of under and over-utilization of behavioral health inpatient and outpatient services. The Plan submitted a narrative response from USBHP which stated:[97]

> At this time, USBHP does not have any policies or procedures regarding the identification, monitoring, and handling of under- and over-utilization of behavioral health services. As a specialized BH Plan, it is the intent of USBHP to remove any access barriers to MH-SUD services whenever possible. As such, USBHP does not monitor under- and/or over-utilization of behavioral services.

None of the documents submitted demonstrated the Plan or USBHP continuously reviewed utilization of behavioral health services as required. As a result of not having a process to monitor and analyze over and under-utilization of behavioral health services, and the limited nature of USBHP's utilization reports, the Plan and USBHP are unable to track and trend the utilization of individual behavioral health services and no meaningful conclusions may be drawn about whether specialty behavioral health care services are being appropriately utilized, or whether utilization of behavioral health care services meets professional recognized standards of practice.

Health plans' quality assurance programs are required to assess trends and implement actions to correct identified problems and monitor whether the provision and utilization of services meet professionally recognized standard of practice.[98] Health plans are also required to "design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities."[99] Utilization that fails to meet professionally recognized standards of practice may result in either over-utilization or under-utilization of services. Amendment Six requires USBHP to monitor and correct potential under and over-utilization of behavioral health services and requires the Plan to monitor this function.

Conclusion: Plan and USBHP documents demonstrated that USBHP does not have a sufficient process for continuously reviewing utilization of services and facilities and does not monitor whether the provision and utilization of behavioral health services meets professionally recognized standards of practice because USBHP does not effectively track over and under-utilization of services. The Plan is failing to ensure USBHP is monitoring the utilization of behavioral health services and, therefore, the Department finds the Plan in violation of Section 1367.01(j) and Rules 1300.70(a)(1) and (3) and 1300.70(c).

[97] Response to Crosswalk Request BHIUM13.
[98] Section 1367.01(j); Rule 1300.70(a)(1) and (3)
[99] Rule 1300.70(c)

GRIEVANCES AND APPEALS

#6: The Plan fails to ensure USBHP is consistently and adequately considering all issues within enrollee grievances and providing rectification when appropriate.

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

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)
- Plan's On-going Delegation Oversight Procedure (September 7, 2022)
- USBHP *Resolution of Enrollee Grievances* (QIC Approved December 2023)
- USBHP *Resolution of Enrollee Appeals* (QIC Approved June 2024)
- 20 USBHP Standard Grievance Files (June 1, 2022 through May 31, 2024)

Assessment: Health plan grievance systems must have reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.[100] 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.[101]

Per Exhibit C of the Master Agreement, the Plan delegated all behavioral health grievance functions to USBHP.[102]

Plan Documents

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

USBHP Documents

USBHP's *Resolution of Enrollee Grievances* policy details a grievance system in which "enrollees are given an opportunity to submit written comments, documents, records or other information for consideration during the grievance investigation."[103] This policy further defines a grievance (or complaint) as "any written or oral expression of dissatisfaction made by an enrollee" and notes a complaint is the same as a grievance.[104] USBHP's *Resolution of Enrollee Appeals* policy defines an appeal as either

[100] Section 1368(a)(1)
[101] Rule 1300.68(a)(4)
[102] *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.*[102] (Master Agreement) (Effective July 1, 2000), page 43.
[103] BHIGA1_Rsltn_Enrl_Griev.pdf, page 1.
[104] Id.

(1) a request for review of a prior non-coverage determination regarding payment of a service or (2) a request to appeal the disposition of a grievance.[105]

File Review

The Department reviewed 20 standard grievance and appeal files and found in eight files[106] (40%) USBHP failed to adequately consider and resolve all issues in the enrollee's grievance. The eight files involved enrollees expressing difficulty obtaining an appointment and/or reporting provider directory inaccuracies. However, none of these files included documentation that the enrollee was offered an appointment nor did the files include any notes that the provider directory inaccuracy was documented and investigated.

Case Examples

- **LFF File #26:** The enrollee filed a grievance with USBHP expressing difficulty obtaining an appointment with a behavioral health specialist for their child. The enrollee had located one in-network provider, who requested the enrollee pay out-of-pocket for the covered behavioral health care services. The case file notes indicated USBHP focused its grievance investigation on the payment aspect and other than forwarding the matter to USBHP's provider relations team, the notes did not reflect any assistance was provided to the enrollee to obtain an appointment with an in-network provider. The notes also indicate USBHP contacted the in-network provider who informed USBHP that they billed the enrollee because USBHP does not reimburse the provider for some procedures. USBHP advised the in-network provider to contact provider relations to discuss contract rates. The grievance resolution letter stated, among other things, the enrollee's difficulty in locating in-network providers was forwarded to USBHP's provider relations team to "address any shortcomings in our referral process that are brought to our attention." There was no evidence the enrollee was offered an appointment or that an in-network provider with availability was identified for the enrollee.

- **LFF File #32:** The enrollee called USBHP expressing frustration with finding an available in-network provider. The enrollee stated the list of providers given to them by USBHP from the provider directory were not accepting new patients. The enrollee also stated one provider scheduled an intake appointment for the enrollee and then told them their practice was full. The grievance resolution letter indicates USBHP conducted a quality of service investigation but did not document or investigate the reported inaccuracy, nor was the enrollee offered an appointment.

The case examples demonstrate USBHP failed to adequately consider enrollee grievances involving difficulty locating in-network providers and failed to provide rectification when appropriate by not identifying in-network providers accepting new patients, offering enrollees appointments, or investigating and rectifying reported

[105] BHIGA1_Rsltn_Enrol_Appl.pdf, page 3.
[106] LFF File #26, #29, #30, #32, #34, #35, #36 and #38

provider directory inaccuracies. The grievances were not resolved because in each case USBHP did not address all issues raised by the enrollee.

Conclusion: Plan and USBHP documents and grievance files demonstrated that USBHP does not adequately consider and rectify all issues within an enrollee's grievance. The Plan is failing to ensure USBHP is complying with grievance system requirements and, therefore, the Department finds the Plan in violation of Section 1368(a)(1) and Rule 1300.68(a)(4).

#7: <u>The Plan fails to ensure USBHP's customer service staff consistently identify enrollee expressions of dissatisfaction as grievances.</u>

Statutory/Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(1)

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)
- USBHP *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours* (QIC Approved: December 2023)
- USBHP *Grievance Overview and CARTA Entry* (Undated)
- USBHP *Resolution of Enrollee Grievances* (QIC Approved December 2023)
- USBHP *Resolution of Enrollee Appeals* (QIC Approved June 2024)
- USBHP 31 Repeat Caller Inquiry Files (June 1, 2022 through May 31, 2024)
- USBHP 13 Call Inquiry Audio Files (June 1, 2022 through May 31, 2024)
- Interview Document Requests sent to the Plan on March 4, 2025

Assessment: Heath plans are required to maintain a grievance system under which enrollees may submit their complaints.[107] A grievance is defined as "a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by the enrollee or the enrollee's representative. When the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance."[108]

Per Exhibit C of the Master Agreement, the Plan delegated all behavioral health care customer service calls and grievance and appeals functions to USBHP.[109]

<u>Plan Documents</u>

As discussed in Violation #1, the Plan's *On-going Delegation Oversight* procedure describes in general how the Plan oversees and monitors its delegates.

[107] Section 1368(a)(1)
[108] Rule 1300.68(a)(1)
[109] *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc*. (Master Agreement) (Effective July 1, 2000), page 43.

USBHP Documents

The Plan submitted documents in response to a request for training materials, job aids and scripts used by the Plan customer service staff in the event an enrollee expresses dissatisfaction with the Plan, Delegate and/or Plan services.[110] In response the Plan submitted USBHP's *Call Triage and Disposition by Non-licensed Staff, Normal Business* and USBHP's *Grievance Overview and CARTA Entry*.

USBHP's *Call Triage and Disposition by Non-licensed Staff, Normal Business*[111] policy defines the scripted intake process for non-licensed customer service staff to follow during normal business hours. The policy describes that a non-licensed staff triages the call based on the enrollee's responses to USBHP's pre-determined script and describes circumstances where customer service would warm transfer the enrollee to a licensed care advocate and circumstances under which the non-licensed staff would handle the call themselves. However, this policy does not describe how to triage a call when the enrollee makes an "oral expression of dissatisfaction."

USBHP's *Grievance Overview and CARTA Entry*[112] describes how USBHP submits complaints into USBHP's electronic complaint and appeal routing and application system (CARTA). The policy includes a definition of a "complaint," as an "expression of dissatisfaction, verbally or written, by an Optum [USBHP] Member or Member's representative that is elevated to the complaint resolution system." This policy also defines an inquiry as "an issue that is resolved during the initial telephone conversation or is a written or oral request for information or action that does not include an expression of dissatisfaction."

The Plan also submitted documents in response to a request for all policies, procedures, and processes pertaining to grievance and appeals used by the Plan, Delegate(s) or other entities contracted by the Plan to perform grievance and appeal functions.[113] In response the Plan submitted USBHP's *Resolution of Enrollee Grievances* policy and USBHP's *Resolution of Enrollee Appeals* policy.

USBHP's *Resolution of Enrollee Grievances* policy[114] details a grievance system in which "enrollees are given an opportunity to submit written comments, documents, records or other information for consideration during the grievance investigation."[115] This policy further defines a grievance (or complaint) as "any written or oral expression of dissatisfaction made by an enrollee" and notes a complaint is the same as a grievance.[116] USBHP's *Resolution of Enrollee Appeals* policy[117] defines an appeal as either (1) a request for review of a prior non-coverage determination regarding payment of a service or (2) a request to appeal the disposition of a grievance.[118]

[110] Crosswalk Request BHICS7
[111] BHICS7_Call_Triage
[112] BHICS7_Grievances
[113] Crosswalk Request BHIGA1
[114] BHIGA1_Rsltn_Enrl_Griev.pdf
[115] Id. p.1.
[116] Id.
[117] Id.
[118] BHIGA1_Rsltn_Enrol_Appl.pdf, p.3.

Interviews

During interviews, the Department asked the Plan how customer service staff would input a grievance into USBHP's CARTA system when an enrollee expresses dissatisfaction. A USBHP representative provided a demonstration and explained the customer service agent would warm transfer the call to an appeals agent.

The Department asked the Plan how they monitor USBHP's customer service to ensure staff are correctly identifying oral expressions of dissatisfaction. The Plan stated USBHP provides reports regarding USBHP's customer service team process but did not provide any additional information regarding how often the reports are submitted or whether the Plan reviews these reports. Subsequently, at the Department's request,[119] USBHP provided a document called the CS scorecard that listed 15 elements used to measure the customer service representatives interactions with the caller, but none of the elements addressed failure to identify expressions of dissatisfaction or to file a grievance.

File Review

The Department reviewed the 13 call inquiry audio files and 31 repeat caller inquiry audio files. In six[120] of the 13 call inquiry audio files, the enrollee expressed dissatisfaction, but in five[121] (83%) of the six files, USBHP failed to identify and consider the call as a grievance. Additionally, in seven of the 31 repeat caller inquiry audio files, the enrollee expressed dissatisfaction, but in six[122] (85%) of the seven files, USBHP failed to identify and consider the call as a grievance.

Table 2

USBHP Call Inquiry and Repeat Caller Inquiry Audio Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiry expressing dissatisfaction	6	USBHP identifies all oral expressions of dissatisfaction as grievances	1 (17%)	5 (83%)
Repeat Caller Inquiry expressing dissatisfaction	7	USBHP identifies all oral expressions of dissatisfaction as grievances	1 (15%)	6 (85%)

- **LFC File #19**: A USBHP case manager called the enrollee's representative to follow up on providing the enrollee with a list of providers. The call notes stated

[119] Document Request #54
[120] LFC File #10, #12, #13, #14, #15 and #19
[121] LFC File #12, #13, #14, #15 and #19
[122] LFC_RP File #1, #10, #14, #15, #16, and #20

the enrollee was "upset" because the previous provider referrals received by the enrollee were not taking new patients. Although the enrollee's representative expressed dissatisfaction, the call was closed with no documentation of a grievance being filed.

- **LFC File #14 and 15**: The enrollee called USBHP twice regarding the denial of an out-of-network RTC placement for their child. In the first call, the call inquiry file notes the enrollee "was upset" that the out-of-network RTC placement was approved and then denied. The notes indicated the call was escalated to the clinical helpline and there was no evidence that USBHP ever initiated a grievance. The enrollee called USBHP again that same day expressing frustration with the RTC denial and demanded to speak to a supervisor. The notes indicated the call was escalated to the clinical helpline and there was no evidence USBHP ever initiated a grievance after the second phone call.

The above case examples demonstrate that USBHP's customer service staff fail to consistently identify oral expressions of dissatisfaction and initiate a grievance when required.[123]

Conclusion: Plan and USBHP's documents, USBHP's call inquiry audio files, and information obtained during interviews demonstrated that USBHP did not consistently identify oral expressions of dissatisfaction as grievances in calls received from enrollees. The Plan is failing to ensure USBHP is complying with grievance system requirements and, therefore, the Department finds the Plan in violation of Section 1368(a)(1) and Rule 1300.68(a)(1).

#8: The Plan's website does not include information about accessing behavioral health care services and other Knox-Keene Act required information, and fails to include a link to USBHP's website

Statutory/Regulatory Reference: Section 1368.015(f)(1) and (2); Section 1368.016(a) and (h).

Supporting Documents:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)

Assessment: Health plans that provide coverage of behavioral health shall maintain an internet website that includes information to subscribers, enrollees, and providers about accessing behavioral health care services and the information described in Section 1368.016.[124] However, if the health plan contracts with a specialized health care service

[123] Section 1368(a); Rule 1300.68(a)(1)

[124] Sections 1368.015(f)(1) and 1368.016(a). The information Section 1368.016(a) requires be included is: (1) a phone number that enrollees and providers can call for information about accessing mental health benefits, benefits, in-network provider access, and claims processing. (2) a link to the prescription drug formulary and how to obtain a copy. (3) a detailed summary of the plan's process for conducting utilization management and the plan's obligations for providing copies of clinical criteria and guidelines, (4) list of

plan or other entity to cover professional mental health care services for its enrollees, it need not comply with Section 1368.016 as long as the health plan provides a link on its internet website to an internet website operated by the contracted behavioral health care plan or other entity and that website complies with Section 1368.016.[125]

Per the Master Agreement, USBHP is delegated behavioral health functions, including grievances and appeals. As such, the Plan's website must either include information about accessing behavioral health care services and the information required under Section 1368.016 or include a link to USBHP's website.

Plan's Website

The Department reviewed the Plan's internet website[126] and was unable to locate a link to USBHP's internet website, and the Plan's website did not include any information about accessing behavioral health care services or include the information required by Section 1368.016.

Interviews

During interviews, USBHP demonstrated how an enrollee could file an online grievance on its internet website. However, the Plan confirmed its internet website did not have a direct link to the USBHP internet website nor did it include the statutorily required information. Therefore, the Plan was unable to demonstrate how an enrollee could obtain information from its internet website about accessing behavioral health care services and the information required by Section 1368.016, including filing a grievance.

Conclusion: Sections 1368.015(f)(1) and (2) and 1368.016(a) require the Plan's internet website to include specified information, including, but not limited to, how to access behavioral health care services and file a grievance. Compliance can be achieved if the Plan includes on its internet website a link to USBHP's internet website, and USBHP complies with the statutory requirements. However, the Plan's website neither included the statutorily required information nor a link to USBHP. Therefore, the Department finds the Plan in violation of the statutory requirements.

QUALITY ASSURANCE

#9. The Plan fails to ensure USBHP's customer service staff are knowledgeable and competent regarding enrollee questions and concerns.

Regulatory Reference: Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10)

providers or how to obtain a list. (5) a detailed summary of the enrollee grievance process (6) a detailed summary how an enrollee may request continuity of care. (7) the enrollee's rights to and how they may request Independent Medical Review from the Department.

[125] Section 1368.015(f)(2)

[126] https://www.uhc.com/ (Accessed April 9, 2025).

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc. (Amendment Six) (Effective August 1, 2004)
- USBHP *Call Triage and Disposition by Non-licensed Staff, During Normal Business Hours* (QIC Approved: December 2023)
- 31 Repeat Caller Inquiries to USBHP (April 1, 2022 through May 31, 2024)

Assessment: Health plans must ensure "during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes."[127] This requirement has two components, a timeframe component and a knowledge and competency component. First, the wait time component limits the wait time to speak with a customer service representative to 10 minutes. Second, the customer service representative who speaks with the enrollee must be knowledgeable and competent about the enrollee's questions and concerns. Both components must be met for a Plan to comply with the legal requirement.

Per Exhibit C of the Master Agreement, the Plan delegated customer service functions to USBHP.[128]

USBHP Documents

USBHP's *Call Triage and Disposition by Non-licensed Staff, Normal Business Hours*[129] defines "the scripted intake process for non-licensed staff to follow during normal business hours when responding to calls from enrollees seeking mental health services for parity and non-parity diagnoses, and for substance abuse disorders." The policy describes how disposition of the call is based on the enrollee's responses to a pre-determined script followed by the non-licensed staff. The policy includes the requirement that "during normal business hours, the wait time for an enrollee to speak by telephone with a Plan representative knowledgeable and competent regarding the enrollee's questions and concerns does not exceed ten (10) minutes," consistent with Rule 1300.67.2.2(c)(10).

The Department reviewed 31 USBHP Repeat Caller inquiry files[130] and audio calls and found in eight (26%)[131] instances, USBHP CSRs handling enrollee phone calls could not knowledgeably and competently address enrollee questions and concerns.

[127] Section 1367.03(a)(10); Rule 1300.67.2.2.(c)(10)
[128] Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc. (Master Agreement) (Effective July 1, 2000), 43.
[129] BHICS7_Call_Triage
[130] LFC_RP USBHP Call Inquiries
[131] LFC_RP File: #1, #5, #11-13, and #14-16.

Case Examples:

- **LFC RP File #1**: The enrollee called USBHP about having been balance-billed by a provider. The USBHP CSR transferred the enrollee to UHC, and the UHC CSR transferred the enrollee back to USBHP. The USBHP CSR informed the enrollee they needed to register to submit a grievance through USBHP's enrollee portal even though the enrollee wanted to file a grievance over the phone. The enrollee was disconnected and called USBHP back for the second time and expressed frustration and anger and asked to speak with a supervisor. The USBHP CSR finally filed a grievance for the enrollee. This file demonstrates the CSRs were not knowledgeable about the process for resolving a balance-billing issue and gave incorrect information about the grievance process, including informing enrollees that a grievance cannot be filed via a phone call.

- **LFC RP #14, #15, and #16:** The enrollee's parent called USBHP twice on February 13, 2024, inquiring about coverage at an out-of-state residential treatment center (RTC) for the enrollee who was being discharged from an inpatient psychiatric facility the next day. The enrollee's parent reported that RTC services were previously approved but now were being denied and was concerned since they were in the midst of arranging transportation to the facility. The CSR informed the parent they would escalate the matter to a supervisor. The enrollee's parent called USBHP again on March 4, 2024, because the enrollee was being discharged from RTC. The enrollee's parent requested the name of the case worker assigned to the enrollee's case and said: "My daughter continues try to kill herself and needs help. Now they want to send her home. They are denying her care". The enrollee's parent also informed the USBHP CSR that the enrollee has had three suicide attempts and nine doctors want her to stay in RTC. The CSR reviewed the file and advised the parent to call back during regular business hours to speak with decision makers and provided a customer service number. Rather than involve USBHP's care advocates to assist the parent with the out-of-state RTC coverage request and process the calls as grievances, the CSRs advised the parent they would escalate to their supervisor or that the parent should call back.

The above examples demonstrate that USBHP's CSRs were not consistently knowledgeable and competent about the variety of issues and questions raised by enrollees.

Conclusion: Review of the USBHP's repeat caller inquiry files and audio calls demonstrated the CSRs were not consistently knowledgeable and competent regarding enrollee questions and concerns. The Plan is failing to ensure USBHP's customer service staff are knowledgeable and competent regarding enrollee questions and concerns and, therefore, the Department finds the Plan in violation of Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

#10: <u>The Plan is acting at variance with its filed delegation agreements by failing to conduct adequate oversight of the behavioral health functions delegated to USBHP</u>

Statutory and Regulatory Sections: Section 1386(b)(1)

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.[132] Included among the types of documents required to be filed are plan-to-plan contracts[133] such as delegation agreements. The Department's BHI found that the Plan is failing to adhere to its delegation agreement and subsequent amendments, as detailed below.

A. Provider Directory Functions

Supporting Documents:

- *Amendment Twenty-Three to the Behavioral Health Services Agreement between U.S. Behavioral health Pan* and *UHC of California* (Delegation Agreement) (Effective Date: July 1, 2016)

The Delegation Agreement delegates provider directory functions, including, but not limited to, establishing provider directory policies and procedures that must be filed with the Department annually.[134] With respect to the Plan's oversight of delegated functions, the Delegation Agreement states the Plan "shall remain liable for its compliance with Section 1367.27, and is responsible for monitoring and oversight of Vendor's [USBHP] responsibilities for network and provider directory."[135]

As required by Section 1352(a), the Plan filed an amendment[136] with the Department that included the Plan's Delegation Agreement. As explained in Violation #1, when enrollees call USBHP or submit grievances about potential provider directory inaccuracies, USBHP staff is not consistently identifying, documenting and investigating such reports. The Plan is operating at variance with its filed Delegation Agreement by failing to conduct adequate oversight of the provider directory functions delegated to USBHP.

B. Appointment Availability and Timely Access

Supporting Documents:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)

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[132] Section 1386(b)(1)
[133] Rule 1300.51(c)P
[134] Section 1367.27(m)(1)
[135] *Amendment Twenty-Three to the Behavioral Health Services Agreement between U.S. Behavioral health Pan and UHC of California* (Delegation Agreement) (Effective Date: July 1, 2016), page 1.
[136] eFiling #20161243

- *Amendment Six to Behavioral Health Services Agreement between PacificCare Behavioral Health of California and PacifiCare Behavioral Health of California* (Amendment Six) (Effective August 1, 2004)

Per Exhibit C in the Master Agreement, the Plan delegated all behavioral health functions to USBHP, including complying with timely access standards. The Master Agreement further states that the Plan shall monitor the performance of duties delegated to USBHP to ensure compliance by USBHP with California laws and regulations.[137] Exhibit C as updated in Amendment Six continues to delegate timely access to behavioral health functions to USBHP. The Plan is responsible for ensuring that USBHP complies with timely access requirements.

As required by Section 1352(a), USBHP filed an amendment with the Department that included the Master Agreement[138] and Amendment Six.[139] As explained in Violation #2 and #3, USBHP fails to consistently offer or arrange for behavioral health appointments within timely access standards when enrollees call or submit grievances about requesting behavioral health appointments or out-of-network services. The Plan is operating at variance with its filed Master Agreement and Amendment Six by failing to conduct adequate oversight of the timely access functions delegated to USBHP.

C. Utilization Management

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)

Per Exhibit C in the Master Agreement, the Plan delegated all behavioral health utilization management functions to USBHP, which includes post-stabilization care utilization management, the Knox-Keene Act required annual notices to non-contracting hospitals, and monitoring for over and under-utilization of behavioral health services.[140] Exhibit C as updated in Amendment Six continues to delegate utilization management functions to USBHP. The Plan is responsible for ensuring that USBHP complies with utilization management requirements.

As required by Section 1352(a), the Plan filed an amendment with the Department that included the Master Agreement[141] and Amendment Six.[142] As explained in Violation #4 and #5, USBHP is failing to comply with all post-stabilization requirements and failing to

[137] Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc. (Master Agreement) (Effective July 1, 2000), page 20.
[138] eFiling #20041082
[139] eFiling #20090030
[140] Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc. (Master Agreement) (Effective July 1, 2000), paged 41-45.
[141] eFiling #20041082.
[142] eFiling #20090030

monitor over and under-utilization of behavioral health services. The Plan is operating at variance with its filed Master Agreement and Amendment Six by failing to conduct adequate oversight of the utilization management functions delegated to USBHP.

D. Grievances and Appeals

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)

Per Exhibit C in the Master Agreement, the Plan delegated all behavioral health grievances and appeals functions to USBHP.[143] Exhibit C as updated in Amendment Six continues to delegate grievances and appeals functions to USBHP. The Plan is responsible for ensuring that USBHP complies with grievances and appeal requirements.

As required by Section 1352(a), the Plan filed an amendment with the Department that included the Master Agreement[144] and Amendment Six.[145] As explained in Violation #2, #3, #6 and #7, USBHP's grievance and appeals department are failing to comply with Knox-Keene Act requirements. The Plan is operating at variance with its filed Master Agreement and Amendment Six by failing to conduct adequate oversight of the grievances and appeals functions delegated to USBHP.

E. Customer Service

Supporting Documentation:

- *Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc.* (Master Agreement) (Effective July 1, 2000)
- *Amendment Six to Behavioral Health Services Agreement PacificCare of California and PacifiCare Behavioral Health of California, Inc.* (Amendment Six) (Effective August 1, 2004)

Per Exhibit C in the Master Agreement, the Plan delegated to all behavioral health grievance and appeal functions, including customer service functions to USBHP.[146] Exhibit C as updated in Amendment Six continues to delegate customer service functions to USBHP. The Plan is responsible for ensuring that USBHP complies with all customer service requirements.

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[143] Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc. (Master Agreement) (Effective July 1, 2000), paged 41-45.
[144] eFiling #20041082.
[145] eFiling #20090030
[146] Behavioral Health Services Agreement between PacifiCare of California and PacifiCare Behavioral Health of California, Inc. (Master Agreement) (Effective July 1, 2000), paged 41-45.

As required by Section 1352(a), the Plan filed an amendment with the Department that included the Master Agreement[147] and Amendment Six.[148] As explained in Violation #1, #2, #3, #6, #7 and #8, USBHP's customer service department is failing to comply with Knox-Keene Act requirements. The Plan is operating at variance with its filed Master Agreement and Amendment Six by failing to conduct adequate oversight of the customer service functions delegated to USBHP.

F. SB 855

Supporting Documentation:

- *Amendment Twenty-Seven to the Behavioral Health Services Agreement between UHC of California and U.S. Behavioral Health Plan* (SB 855 Agreement Amendment) (Effective January 1, 2021)

The SB 855 Agreement Amendment describes the functions delegated to USBHP to ensure USBHP complies with Sections 1374.21 and 1374.721. The SB 855 Agreement further states "For the sake of clarity, all Utilization Management functions as defined by Section 1374.721(f)(3), are hereby delegated to USBHP."[149] The SB 855 Agreement further describes the Plan and USBHP's agreement to comply with all applicable provisions required under Sections 1374.72 and 1374.721. Lastly, the SB 855 Agreement confirms the Plan's oversight and monitoring obligations as set forth in Section 3.12 of the Master Agreement and Exhibit C Delegation Standards and Oversight.[150]

As required by Section 1352(a), the Plan filed an amendment with the Department that included the SB 855 Agreement.[151] As explained in Violation #3, USBHP is failing to arrange for behavioral health services in a timely manner and failing to refer enrollees to out-of-network providers when in-network services were not available within those standards. The Plan is operating at variance with its filed SB 855 Agreement Amendment by failing to conduct adequate oversight of the SB 855 functions delegated to USBHP.

Conclusion: The Plan is failing to monitor whether USBHP is providing required behavioral health care services to its enrollees. The delegation agreements between the Plan and USBHP specify that the Plan remains responsible for compliance with all applicable California laws and regulations, and shall ensure that USBHP complies with all applicable California laws and regulations. However, the Plan is failing to conduct adequate oversight of the behavioral health functions delegated to USBHP and is therefore operating at variance with its filed delegation agreements and is subject to discipline under Section 1386(b)(1).

[147] eFiling #20041082.
[148] eFiling #20090030
[149] Amendment Twenty-Seven to the Behavioral Health Services Agreement between UHC of California and U.S. Behavioral Health Plan (SB 855 Agreement Amendment) (Effective January 1, 2021), page 2.
[150] Id., page 3.
[151] eFiling #20212101

#11: <u>The Plan failed to file its On-going Delegation Oversight policy and procedure with the Department</u>

Statutory/Regulatory References: Section 1351(m), 1352(a), and Rule 1300.52.4(b)(i)(A)

Supporting Documents:
- Plan's *On-going Delegation Oversight Procedure* (September 7, 2022)
- Request Sent to the Plan on October 15, 2025
- Plan Response Received on October 16, 2025

Assessment: A health plan's application for licensure shall be accompanied by a description of the procedures and programs for internal review of the quality of health care.[152] A health plan shall, "within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment hereto in the manner the director may by rule prescribe setting forth the changed information."[153] If a health plan makes any change to one or more of the items specified in Section 1351 of the Act, the plan shall file an amendment to its plan license application within 30 days after the plan implements that change.[154]

The Department requested the Plan provide its policies and procedures, and to identify any applicable eFiling numbers if filed with the Department, describing any delegation oversight processes of quality assurance, utilization management and/or grievance and appeals to ensure consistent, effective, and appropriate oversight of these functions.[155] The Plan provided its *On-going Delegation Oversight* procedure, which states that the Plan's "Chief Medical Officer (CMO) and the CA Medical Management Consultants (MMC) provide on-going monitoring of all aspects of Delegate responsibilities, and adherence to contractual relationships."[156]

The Plan's response[157] did not indicate whether the *On-going Delegation Oversight* procedure was filed with the Department. The Department asked the Plan to confirm whether the Plan filed this procedure before or during the BHI review period.[158] The Plan responded that it did not file the procedure with the Department before or during the BHI review period.[159]

Conclusion: The Plan is required to file any changes to policies and procedures describing its internal review of the quality of health care within 30 days after implementing the change.[160] The *On-going Delegation Oversight* procedure states that it was effective on January 17, 2019, and revised during the BHI review period on September 7, 2022. However, the Plan failed to file the procedure within 30 days after its effective date of January 18, 2019, or within 30 days after revising the procedure on

[152] Section 1351(m)
[153] Section 1352(a)
[154] Rule 1300.52.4(b)(i)(A)
[155] Crosswalk Request BHIQA4
[156] Response to Crosswalk BHIQA4_On-going Delegation Oversight
[157] Id.
[158] Request sent to the Plan on October 15, 2025
[159] Plan Response Received on October 16, 2025
[160] Section 1351(m), 1352(a); Rule 1300.52.4(b)(i)

September 7, 2022. Therefore, the Department finds the Plan in violation of Section 1351(m), 1352(a), and Rule 1300.52.4(b)(i)(A).

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

Summary: Health plan approvals of medically necessary behavioral health services are crucial for enrollee access to care. When a health plan denies a service based in whole or in part on a determination that the requested service is not medically necessary, the enrollee may file a grievance with the health plan.[161] All enrollee grievances involving a denial, modification, or delay of a requested behavioral health care service are eligible for review under the Department's IMR process.[162] The IMR processes uses medical experts that are independent from any health care service plans to review whether the requested service is medically necessary.[163] The IMR decision on whether the requested service is medically necessary is adopted by the Department as final and is binding on the health plan.[164]

USBHP's *Resolution of Enrollee Grievances* and *Resolution of Enrollee Appeals* policies describe USBHP's internal grievance and appeals processes and how USBHP tracks and trends enrollee complaints. The policies state, in relevant part, that "complaints are analyzed and trended on a quarterly basis." However, these policies only track and trend USBHP's internal grievances and appeals, not complaints submitted through the Department's IMR process. The Department located USBHP's most recently filed

[161] Section 1368
[162] Section 1374.30(d)(1).
[163] Sections 1374.32(a) and 1374.33(a)
[164] Section 1374.33(f)

Independent Medical Review policy, which describes USBHP's process for responding to IMR complaints submitted by the Plan's enrollees with the Department. Unlike USBHP's grievance policies described above, the IMR policy does not include a process for tracking, trending and/or analyzing IMR complaints.

If most of a health plan's denials are being overturned through the Department's IMR process, it may indicate that the health plan is inappropriately denying medically necessary behavioral health services and creating barriers to care for its enrollees. The Department found that USBHP's denials of behavioral health services during the review period were overturned by IMR 76%[165] of the time, meaning the IMR physician or panel found those requested services were medically necessary and overturned USBHP's denial. The Department adopted those decisions and required USBHP to cover the requested service. This data indicates USBHP may be inappropriately denying medically necessary behavioral health services, requiring enrollees to file a grievance with USBHP disputing the medical necessity denial, and appeal those denials through the Department's IMR process to access medically necessary services.

During interviews, USBHP's behavioral health director was asked if they review the IMR overturns to look for trends or to determine if incorrect criteria were applied and USBHP stated they do not. USBHP's behavioral health director stated they had reviewed the report prior to the interviews but that reviewing this information is not in their current process.

If a high percentage of enrollee complaints submitted to IMR are being overturned by the Department's IMR process, that may indicate the Plan and USBHP may be inappropriately denying medically necessary behavioral health services and causing unnecessary barriers to behavioral health care. This barrier may cause, among other issues, delays in enrollee access to medically necessary care by having to file appeals, not receiving medically necessary care at all, or dissuade providers from recommending services that the Plan or USBHP may deny. As a result of not tracking and analyzing IMR overturn data, the Plan is missing an opportunity to identify problems, including potentially widespread or institutional problems, and implementation to actions to correct those problems.

#2. <u>USBHP does not track all single case agreement (SCA) requests to identify potential gaps in network coverage</u>.

Summary: Health plans must execute SCAs with out-of-network providers when in-network providers are not available within geographic and timely access standards or for other various reasons, such as a shortage of providers in a certain area, no qualified specialists available, continuity of care, etc.[166] If a health plan receives a high volume of SCA requests from out-of-network providers and/or enrollees, it may be an indication that the health plan has gaps in its network, or providers do not want to contract with the health plan, or enrollees may not be able to access care timely or any combination thereof.

[165] Crosswalk to BHIUM20_USBHPC_IMR_Data
[166] Sections 1367.03(a)(1) and 1374.72(d)

USBHP submitted a report documenting the number of SCA requests it received during the review period and the number that were executed and signed by the out-of-network provider. The report indicated USBHP received approximately 395 SCA requests during the review period. Of those SCA requests, 190 (48%) were offered by USBHP but were never signed and/or returned by the provider, meaning the provider may have found terms of the SCA unacceptable, such as reimbursement rates, or the provider did not desire to sign an agreement with USBHP.

USBHP also tracks access complaints in its Access and Availability Work Group but does not track SCA requests. In the Access and Availability Work Group report for August 2022,[167] USBHP detailed 16 behavioral health complaints related to access for Q2 2022. This report lists action items including increased provider recruitment, expansion of the Telemental Health Network, and assessment of SCA's in California and utilization of this data for recruitment. The report for Q2 2023[168] showed USBHP had 49 behavioral health complaints related to access and availability, a notable increase in access complaints. Of these access complaints, 31 (63%), were related to in-network providers/specialists not being available within timely and geographic access standards, likely necessitating USBHP to attempt to enter into a SCA.

During interviews, USBHP's Director of Provider Relations was asked what is being done to increase availability of in-network providers since access complaints increased over the past two years. The Director of Provider Relations responded that USBHP is always working on improving the network but did not provide any specific actions being taken. The Director of Provider Relations was also asked why there was such a high number of SCAs that are not signed and returned by the provider. USBHP responded that providers are busy and oftentimes do not return signed SCAs. USBHP's Director of Quality acknowledged that USBHP does not analyze the number of SCA requests received, why it receives that many, or why out-of-network providers may not be signing and returning the SCAs.

As a result of not having a process to track SCA requests, USBHP may be missing opportunities to identify gaps in its network that cause a barrier to timely access to care for the Plan's enrollees. As an example, 141 (35%) of the SCA requests were for inpatient and/or residential treatment facilities, indicating that USBHP may have a gap of inpatient and residential based treatment facilities. Identifying the reasons for potential gaps in its network could assist USBHP in understanding why providers are not contracting and what USBHP could do differently to bring more providers in-network.

#3. <u>USBHP does not track and trend repeat callers to identify patterns and problems that enrollees may experience in accessing behavioral health care.</u>

Summary: The Department requested documentation of the Plan's tracking of repeat callers and instances of when an enrollee contacted the Plan more than once for the same behavioral health issue. USBHP provided repeat caller data from July 2023

[167] Delegate Access and Availability Work Group Minutes August 9, 2022; Crosswalk to BHIQA9_Mins_080922.
[168] Delegate Access and Availability Work Group Minutes August 8, 2023; Crosswalk to BHIQA9_Mins_080823.

through May 2024.[169] Of the 49 repeat calls wherein enrollees called USBHP more than once about the same behavioral health related issue, seven calls were from one enrollee, six calls were from another enrollee, five from one enrollee, and at least two enrollees called three times. The most common reason why enrollees were repeat callers was difficulty in locating available in-network providers and obtaining referrals. Additionally, six calls represented three individual enrollees calling again about the same issue in which notes indicate that each issue was resolved on the call. If USBHP were adequately tracking repeat caller info, it would realize that a repeat call about the same issue may indicate the issue was not resolved.

During interviews, USBHP was asked if repeat caller data was reviewed to track issues or identify enrollees whose issues were not resolved by the CSRs. USBHP's Regional Manager of Behavioral Health Member and Provider Services stated USBHP listens to repeat calls and escalated calls but did not describe any process or actions USBHP takes in response to listening to such calls, such as identifying trends in repeat calls or assessing access issues.

By not having a system to accurately track and trend repeat callers, the Plan and USBHP are 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 behavioral health care services.

#4. <u>USBHP's standard fee schedule may create a barrier to increasing and retaining the number of in-network behavioral health care providers sufficient to meet the needs of the Plan's enrollees.</u>

Summary: USBHP's payment rates are considered low by providers and USBHP's reimbursement practices create barriers for providers, thus impeding the ability to improve access by increasing the number of network providers.

USBHP's 2023 *Behavioral Health Provider Survey Results – California,* indicated that commercial provider reimbursement satisfaction increased from 46% in 2022, to 49% for 2023. While the report appears to tout the increase to 49% as an improvement, and "slightly higher than national performance," the results indicate that a majority of the Plan's in-network providers are not satisfied with USBHP's reimbursement rates.

USBHP's *Quality Improvement and Utilization Management Programs 2023 Evaluation* included results from a "Clinician Satisfaction Survey," which identified "Lack of provider satisfaction with reimbursement rates," as a barrier. The "Interventions," column for this barrier stated that USBHP, "Negotiated changes to provider reimbursement (07/14/23)," without any additional detail.

USBHP's reimbursement rates are perceived as low by providers which could pose barriers to providers joining USBHP's network and, therefore, a barrier to the Plan's enrollees accessing USBHP in-network providers.

[169] 9_Repeat_Caller_Data.xlsx

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

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

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

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified 11 Knox-Keene Act violations and five 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.

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

The Plan may submit a statement describing actions the Plan has or will take to address the five 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 Monday, February 9, 2026, using the DMHC Web Portal process described below.

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 11 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 e-Filing link.
- Click the Online Forms link
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2025 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
Oksana Meyer	Assistant Deputy Director
Holly Pearson	Assistant Chief Counsel
Owen Zion	Attorney III
Jennifer Sharifi	Attorney III, Observer
Tammy McCabe	Attorney IV, Observer
Kimberly Galli	Staff Services Manager II
Nakisha Willis	Health Program Specialist II

CONSULTANT TEAM MEMBERS: MAXIMUS

Name	Title
Joan R. Kirby, JD	Project Director
Julie Morgan, LCSW	Manager
Beverly Grimshaw, MD	Investigator
Joshua Jones, MD	Investigator
Andrew Mendonsa, PsyD	Investigator
Alessandra Beers, RN	Investigator
Sherri Field, RN	Investigator
Tammy Lander, PsyD	Observer

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: UNITEDHEALTHCARE OF CALIFORNIA

Name	Title
Archana Dubey, MD	Plan Medical Director
Shelby Cuevas	Associate General Counsel, Regulatory Affairs, CA
Peggy Bouzari	Vice President, Network Programs/West
Abigail Arechiga	Manager Network Programs
Jeanine Ertel	Market Quality Director, CA
Stacie L. Grassmuck	Director, E&I Commercial Product
Rebecca de la Torre	Associate Director, Market Conduct
Marie Hurtado	Regulatory Affairs Consultant, Market Conduct
Stew Newman	Deputy General Counsel
Laury Bowman	Vice President, UCS Regulatory Adherence
Frederick Schneider	Associate Director, UCS Regulatory Adherence
Stephen Campbell	Associate Director, MHP Clinical Services
Jeri Applegate	Associate Director, Credentialing
Linda Hickman	Network Program Consultant Credentialing
Samantha Tate, Pharm. D.	Manager Clinical Pharmacy Operations, UHC
Carolyn Iteen	Director Clinical Pharm
Jennifer Hardwick	Senior Project Manager
Jason Diani	Network Contract Associate Director, UHN West Region

Name	Title
Jacqueline Simpson	Vice President, Network Contracting
Jason Mamawag	Manager Claims
Darlene Kelley	Supervisor Claims
Leah Adams	Associate General Counsel
Fernando Andrade	Director, Regulatory Affairs Consultant
Samantha Uiagalelei	Regulatory Affairs Consultant
Linda S. Johnson	Supervisor, Customer Service
Salvador Gonzalez	Supervisor, Customer Service
Latoya T. Wilson	Supervisor, Customer Service
Shauna Vazquez	Front line agent/SME, Customer Service
Janet Hoffman	Associate Director, UCS E&I Appeals
Samantha Bridge	RN Manager, Clinical Appeals
Camila Lucasey	Director Medical Clinical Ops, Delegation Adherence
Kyle Reed	Associate Director Medical Clinical Ops, Delegation Adherence
Stephanie York	Clinical Quality Consultant, Delegation Adherence

DELEGATE STAFF INTERVIEWED FROM: USBHP

Name	Title
Joan Odom, MD	Behavioral Medical Director, USBHPC
Kendra Quinton	LMFT, President & Director of Clinical Operations for USBHPC
Maribel Paloma M Fuentes	Manager, Care Advocate

Name	Title
Shawn Weber, PhD	Director of Quality Improvement
Cynthia McMasters	Clinical Quality Sr. Analyst
Richard Rodriguez	Director, Provider Relations
Stephanie Ibarra	Regional Manager Behavioral Health Member & Provider Services
Justin Cabuhat	Associate Director USBHPC Compliance
Pamela Mobberley	Sr. Associate General Counsel
Supriya Amar	Associate Director, Compliance, Optum Exam Management
Danielle Cayemberg	Compliance Consultant, Optum Exam Management
David Novell	Director, Compliance, Optum Exam Management
Kechia Mignault	Compliance Analyst, Optum Exam Management
Lorette Urban	Regulatory Adherence, Sr. Consultant
Jeffrey Meyerhoff, MD	Sr. Behavioral Medical Director
Tina Crawford	Clinical Quality Sr. Analyst
Frances Bridge	Associate Director, Medical Clinical Ops
Jeffrey Uy, MD	Behavioral Medical Director, USBHPC
Kimberly Harberts	Associate Director, Credentialing
Alicia Muellner	Credentialing Specialist
Lindsey Good	Claims Quality, Sr. Analyst
Brady Carlson	Claims Auditor, Consultant
Dillion Moyer	Pharmacist

Name	Title
Christine Parrish	Manager, Internal Audits
Leonard Punzalan	Manager, Internal Audits
Andrea Alteri	Associate Director, Pharmacy PA/Appeal, OptumRX
Joshua Meyer	Manager Business Process, OptumRX
Sameen Ghani	Pharmacist
Robinawitz D Williams II	Sr. Business Process Analyst
Sabrina Lih	Director, Healthcare Economics
Shawndee Guillory	SCA Supervisor
Michelle Breazell	Claims Business Process Tech Appeals
Judith Teter	Associate Director MH Parity
Edward Risser	Sr. Parity Consultant
Angie Radford	Manager, Clinical Quality
Nancy Camerino	Provider Data Reporting, Project Manager
Lusine Panosyan	Compliance Consultant
Beverly Rincon	Supervisor, Customer Service
Vanessa Murray	Customer Service Representative
Susan Wagers	Complaint Manager
Amy McLeod	Manager, EAP
Trent Olson	Director Capability

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

A-1 – Prior and Retrospective Utilization Management (UM) Authorizations, Modifications and Denialsfor Behavioral Health (BH) Services

LFA-1 RX (Files Reviewed: 4)

Plan File #
PA-A2211297
PA-A5337182
PA-C5963418
PA-C8219727

LFA-1 BH (Files Reviewed: 18)

Plan File #
1714215487
411652298
209329769
613994744
14017625
808587231
8665310
109590139
716034679
515727975
1415549309

Plan File #
1808297977
909650499
313915273
412255904
511501691
207237074
610421654

A-2 – Concurrent Utilization Management (UM) Authorizations, Modifications and Denials for Behavioral Health (BH) Services

LFA-2 RX (Files Reviewed: 8)

Plan File #
PA-A3278443
PA-B9797899
PA-C7714403
PA-B6151014
PA-B4940582
PA-C6403802
PA-C6496759
PA-A8740304

LFA-2 BH (Files Reviewed: 20)

Plan File #
1216794407
815382267
613618603
809340466
15540400
808230076
210398071
1513408005
1014108205
1907415778
1508717466
908236205
1412887855
1407767738
513184478
1808791370
1909258180
910196664
412763676
1314563268

B – Benefit/Coverage/Experimental/Administrative Denials or Modifications of BH Services

LFB_BH (Files Reviewed: 15)

Plan File #
216404749
1114506303
107411417
807894927
1412887855
316401809
2113609183
913046565
1213366870
912236958
1810453015
1010850755
214480258
115567945
1211209089

LFB_RX (Files Reviewed: 6)

Plan File #
PA-C4394785
PA-B4854353

Plan File #
PA-C8758867
PA-A1616559
PA-C6800258
PA-C9466520

C – Enrollee Inquiry Contacts

LFC (Files Reviewed: 21)

Plan File #
29WGQL4F
46RJG5BI
4CQMVQTE
4CX1RFRF
6WZ2L94R
7191WG83
8T8R8HB2
C57P256U
CPWLXM5U
D3FL5TZU
DBF4QC15
FM8G5DK3
HDJQ5FLC
I7V8WTHZ

Plan File #
JWZ5F8BE
K99GBP2F
PXHM55RQ
RYWK3X3Q
VZSRMCFD
X9DP22JW
YNYGQF3S

LFC_PL (Files Reviewed: 10)

Plan File #
29WGQL4F
46RJG5BI
4CQMVQTE
4CX1RFRF
6WZ2L94R
7191WG83
8T8R8HB2
C57P256U
CPWLXM5U
D3FL5TZU

LFC_RP (Files Reviewed: 10)

Plan File #
7JHNY73U
86ZFMY4F
KZ5TQCQ2
IJQKQ8W3
2TWDJ4P6
AQY9FZFY
QSQZLPWW
FQY28FGF
A4SG62NL
X5NM5K4U

D – Enrollee Requests for Out-of-Network Coverage for a BH Provider

LFD (Files Reviewed: 24)

Plan File #
209911151
210299382
212467186
215889062
307734112
307858706
412604935

Plan File #
415087687
515727975
615161707
812426198
814853147
907550091
907894938
909596240
909650499
1007649956
1015695724
1214775008
1215823326
1215823892
1215992020
1315065414
1409782933

E – Provider Complaints and Disputes

LFE (Files Reviewed: 35)

Plan File #
202207209165

Plan File #
202305161625
202310134544
202310276778
202401229366
507988595
808782815
508881246
1309627990
1809990564
509946550
1810370315
914192012
716743591
107351121
207917246
1707872022
1908012430
108411242
1509523175
1909370661
609808550

Plan File #
10067628
1110471164
1110934004
607398093
7361091
607558899
307995865
709252465
2109973183
713625117
816026612
1607812938
608081824

F – Grievances and Appeals

LFF (Files Reviewed: 40)

Plan File #
913129729
1012383851
1710024650
2112520998
1715616915

Plan File #
313323943
1016241668
1711908183
1615193602
415468742
2113578477
415224200
615383597
1408587255
714463901
1414297569
1009222816
615587462
1809260886
309403233
20230829915
202306136522
20230918465
20240304634
202403154858
202306304879

Plan File #
202206013973
202307137540
202211164247
202403065242
202210187250
202209066059
202403291651
202301055502
202208265696
202402125104
202401033444
202404228675
202301277932
202306026254

H – Claims for BH Services

LFH (Files Reviewed: 28)

Plan File #
220010848500
23X006249000
23X026692502
23X099301601

Plan File #
23X137426601
23X238872401
23X589857900
230010865500
23X768399500
23X839975901
23X969439900
23X322886701
23X394819301
24XA97130700
24XA17313800
24XA21397300
24XA93733302
24XB46524300
24XB98329500
24XC61680800
24XC99528000
24XE03423900
24XD51540201
24XE12936502
24XE30746801

Plan File #
24XE30716700
24XE12902100
24XE76023202

I – Potential Quality Issues (PQIs)

LFI PQI (Files Reviewed: 7)

Plan File #
22-06-02
22-07-10
23-06-03
23-07-08
23-10-06
24-01-06
21-08-10

J – BH (MH/SUD) ER Services

LFJ (Files Reviewed: 40)

Plan File #
22X741885400
24XB88323500
24XB59588600
23X331773700
23X897764301

Plan File #
23X598925900
23X137335700
24XB70574500
23X732790100
24XC28710700
23X797137600
23X407151901
22X828725000
23XA26149100
22X744298200
23X258506500
23X261498600
23X658434200
24XE81005500
22X834332400
23X604811600
24XB24169800
23X749805500
23X755323001
23X084998300
24XB09096700

Plan File #
23X470132101
23X401348700
24XB38133300
22X569076800
23X156890700
24XC26639901
24XB73269301
22X838315000
22X843023500
23X258688400
22X583869900
22X975940900
23X151737901
23X746275700

UnitedHealthcare of California
Corrective Action Plan Response

Appointment Availability and Timely Access

Violation 1:
UHC of California dba UnitedHealthcare of California (Plan) fails to ensure U.S. Behavioral Health Plan, California (USBHP) consistently identifies, investigates and documents potential provider directory inaccuracies reported to USBHP's customer service and grievance departments.

Conclusion:
Plan and USBHP documents, call inquiry files, and grievance files demonstrated that enrollee reports of potential provider directory inaccuracies to USBHP's CSRs and grievance unit staff are not consistently documented, investigated and/or corrected in USBHP's provider directory database. Furthermore, the issues are not consistently documented, reported, investigated or incorporated into the grievance system. The Plan is failing to ensure USBHP is complying with provider directory requirements and, therefore, the Department finds the Plan in violation of Sections 1367.27(e)(1), 1367.27(j)(3), 1367.27(o)(1), 1367.2(o)(2)(B), and 1367.27(n)(2).

Plan Response:

USBHP

USBHP Documents
USBHP provides the following clarification regarding its grievance system and provider directory accuracy processes. USBHP respectfully submits that its policies, when read collectively, establish a compliant framework for the investigation, documentation, correction, and reporting of provider directory inaccuracies, consistent with the Knox-Keene Health Care Service Plan Act and applicable regulations.

USBHP clarifies that its policy titled "Resolution of Enrollee Grievances" expressly cites the Plan's obligation to investigate all grievances received, determine whether the matter meets the definition of a grievance under Knox-Keene, and take appropriate responsive action. This includes grievances arising from an enrollee's reasonable reliance on inaccurate, incomplete, or misleading provider directory information.

Consistent with Health and Safety Code sections governing grievance systems and consumer protections, the policy requires that grievances be logged, investigated, and resolved within applicable timeframes, with appropriate documentation of violations and outcomes.

While the "Resolution of Enrollee Grievances" policy establishes the grievance intake and response obligations, USBHP maintains a separate, dedicated policy that governs the investigation, documentation, and correction of provider directory inaccuracies. This policy, titled "BHICS14_ProvDirDevVerMain," was previously provided to the Department, including during the Behavioral Health investigation.

Specifically, Section D of the "BHICS14_ProvDirDevVerMain" policy details the Plan's process when a provider directory inaccuracy is reported, whether by an enrollee, provider, or other source. This process includes:

- Documentation of the reported inaccuracy
- Verification and investigation of the reported information
- Follow-up with the provider to obtain clarification or updated information, as necessary
- Implementation of appropriate corrective actions to ensure directory accuracy
- Expedited updates to the provider directory when inaccuracies are confirmed and urgent correction is warranted

In alignment with Knox-Keene requirements related to transparency and access to accurate provider information, USBHP's provider directory policy further provides mechanisms to:

- Promptly update the provider directory to reflect verified corrections
- Utilize live-feed update capabilities within the Plan's online provider directory
- Allow the public to submit feedback and report potential inaccuracies through the Plan's online provider directory e-feedback process

These processes are designed to ensure that provider directory information remains accurate, current, and reliable for enrollees seeking timely access to care.

As noted in the "Resolution of Enrollee Grievances" policy, when an enrollee reasonably relies on inaccurate, incomplete, or misleading provider directory information, USBHP provides coverage for services that result from such reliance, consistent with Knox-Keene consumer protection standards. This coverage determination is made in parallel with, and independent of, the Plan's investigation and correction of the underlying directory inaccuracy.

USBHP respectfully submits that, although the "Resolution of Enrollee Grievances" policy does not restate the operational steps for investigating provider directory inaccuracies, those steps are fully addressed in the Plan's "BHICS14_ProvDirDevVerMain" policy, which governs investigation, documentation, corrective action, and public updates related to provider directory accuracy.

Together, these policies establish a comprehensive and compliant framework that ensures:

- Appropriate grievance investigation and resolution
- Timely identification and correction of provider directory inaccuracies
- Protection of enrollees who reasonably rely on Plan-published information
- Ongoing compliance with Knox-Keene requirements for access, transparency, and consumer protection

File Review

LFC Files (Customer Service)

USBHP will provide targeted team re-education to reinforce how to properly identify and classify a grievance and the correct process for documenting and reported potential provider directory inaccuracies. USBHP aims to complete training by February 28, 2026.

Additionally, quarterly reminders will be distributed to all relevant teams to reinforce grievance identification requirements and reported potential provider directory inaccuracies. USBHP finalized the Q1 2026 quarterly reminder in January 2026. Additional reminders are scheduled for completion in the following quarters.

Outcome Measures:
Ongoing compliance with the Knox Keene requirements and established policies and call handling requirements will be validated through supervisory oversight and weekly quality call audits. Supervisors will routinely review call activity to ensure adherence to regulatory requirements, internal procedures, and documentation standards.

Weekly quality audits will be used to assess performance, identify trends, and detect any gaps in compliance. Audit results will be tracked and analyzed to determine whether corrective actions are effective and to identify opportunities for reinforcement, targeted coaching, or additional training, as needed. USBHP aims to implement the weekly call audit and monitoring February 16, 2026.

LFF Files (Grievance):
USBHP will develop an enhanced end-to end streamlined process to ensure compliance with the Knox Keene requirements and timely referral to the Network Management/Provider Relations Advocate (PRA) team to investigate reported potential provider directory inaccuracies and sufficiently document the investigation activities and outcomes. USBHP aims to complete the development of the enhanced process by March 1, 2026.

Targeted education will be provided to the Complaint Reviewers on expectations for accurately identifying, reporting, and documenting provider directory inaccuracies to the Network Management/Provider Relations Advocate (PRA). USBHP aims to complete Grievance staff training by March 15, 2026.

Outcome Measures:
Quarterly reports will be reviewed to ensure that all complaints related to provider directory inaccuracies are consistently identified, appropriately referred for investigation, and supported with complete documentation. The review will evaluate timeliness of referrals, accuracy of categorization, and adequacy of investigative follow-through. Trends will be analyzed to confirm improvement in the handling of directory-related complaints.

Sustained adherence over two consecutive quarters will indicate that the corrective action has been effective and that processes for managing provider directory accuracy issues are functioning as intended.

USBHP aims to implement Grievance quarterly monitoring in Q2 2026 for review period Q1 2026.

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with provider directory requirements as included in Sections 1367.27(e)(1), 1367.27(j)(3), 1367.27(o)(1), 1367.27(o)(2)(B), and 1367.27(n)(2).

Supporting Documentation:
Violation 1_Customer Service_Rprt Invalid Provider Directory Info_BH
Violation_1_Customer Service_Qrtly Reminder

Violation 2:
The Plan fails to ensure USBHP consistently offers enrollees behavioral health appointments within the timely access standards when they call or submit grievances about requesting behavioral health appointments.

Conclusion:
Plan and USBHP documents, call inquiry and grievance files demonstrated USBHP's processes fail to ensure enrollees are consistently offered appointments within timely access standards. The Plan is failing to ensure USBHP is complying with timely access requirements and, therefore, the Department finds the Plan in violation of Sections 1367.03(a)(1), and (a)(5)(D), (E), 1368(a)(1) and (4), and Rule 1300.67.2.2(b)(2), and (c)(5)(D) and (E).

Plan Response:

USBHP

USBHP Documents
USBHP provides the following clarification regarding its grievance system, when viewed in conjunction with the Plan's broader policy framework, adequately addresses grievances involving delays or difficulty in obtaining appointments for covered behavioral health services, consistent with the Knox-Keene Health Care Service Plan Act of 1975 and applicable timely access regulations.

USBHP maintains multiple interrelated policies that collectively govern enrollee access, availability of behavioral health services, and grievance investigation and resolution. All staff are required to comply with and apply these policies in a coordinated manner based on the nature and subject matter of the grievance.

The policy titled "Resolution of Enrollee Grievances" (Policy 400.0.03) establishes the overarching requirements for receiving, documenting, investigating, and resolving enrollee grievances, including adherence to statutory timelines, written response obligations, and escalation as appropriate. This policy is intended to reflect the general grievance system requirements under Knox-Keene, including evaluation of quality of care, clinical matters, access concerns, and provider directory issues.

When a grievance is received that involves a delay or difficulty in obtaining an appointment for covered behavioral health care services, USBHP's grievance staff do not evaluate such complaints in isolation. Instead, staff defer to and apply the Plan's subject-matter-specific access and behavioral health policies, including but not limited to:

- Policy 200.1.01 – Initial Authorization for Behavioral Health Services, which governs intake, authorization processes, and associated timelines
- Policy 100.0.08 – Access to Behavioral Health Services, which addresses timely access standards, enrollee pathways to care, and coordination of services
- Policy 100.0.10 – Availability of Behavioral Health Providers, which addresses network adequacy, appointment availability, and provider access requirements

These policies operationalize the Plan's compliance with Knox-Keene timely access standards and provide the criteria necessary to investigate, substantiate, and resolve grievances alleging access barriers, including appointment delays.

While Policy 400.0.03 outlines the grievance system structure and response requirements, the investigation, follow-up activities, and corrective actions appropriate to a grievance involving delayed access are governed by the applicable access, authorization, and network availability policies listed above.

Depending on the facts of the grievance, investigation activities may include:

- Review of appointment availability and provider access data
- Assessment of authorization timeliness and administrative processing
- Evaluation of network adequacy or referral pathways
- Implementation of corrective actions, which may include expedited access arrangements, provider outreach, or network development measures

This approach ensures grievances are resolved using clinically and operationally appropriate standards, rather than a single generalized process, and aligns with Knox-Keene's intent that health care service plans maintain effective systems to ensure timely access to medically necessary care.

In conclusion, USBHP respectfully disputes the Department's violation indicated herein. USBHP respectfully submits that its grievance system is not limited to a single policy document, but functions through a coordinated and integrated policy structure designed to address the full range of enrollee complaints, including those involving delays or difficulties in obtaining appointments for behavioral health services.

Policy 400.0.03 establishes the grievance intake and resolution framework, while the investigation and corrective action steps are governed by the Plan's behavioral health access, availability, and authorization policies, which collectively ensure compliance with Knox-Keene timely access, access to care, and consumer protection requirements.

Accordingly, USBHP respectfully disputes the violation and defers the Department to the Plan's policies collectively, which together provide clear guidance for processing, investigating, and resolving grievances related to access to covered behavioral health services.

File Review

USBHP respectfully disputes the violation for LFC9, LFC12 and LFC15 files.

LFC9: On September 14, 2022, the member's mother contacted Customer Service requesting assistance with scheduling an appointment. During that call, the Customer Service Representative (CSR) reviewed in-network availability and provided the mother with two (2) in-network (INN) provider options, both of which had appointment availability on September 15, 2022.

Subsequently, the member's mother contacted Customer Service again after reporting that she had received voicemail messages when reaching out to the two (2) INN providers. During this follow-up call, the mother requested consideration for a Single Case Agreement (SCA). In accordance with established procedures, the CSR transferred the call to the clinical team to initiate intake and evaluation of the SCA request.

The SCA request was reviewed and approved on September 16, 2022, contingent upon receipt of the out-of-network provider's executed eAccom agreement letter, including acceptance of the established reimbursement rates.

The approval ensured continuity of care for the member while maintaining compliance with network access requirements and internal authorization processes.

Additional supporting documentation is being provided, as noted in Supporting Documentation below.

LFC12: On October 25, 2025, the member contacted Customer Service. During this interaction, the member was identified as being in distress. Consistent with Knox-Keene Act requirements to ensure appropriate assistance and timely access to covered services, the call was escalated to the Care Advocacy Team for further support.

On the same date, the Care Advocacy Team submitted a request to the Care Appointment Search Team (CAST) to facilitate access to in-network (INN) provider options in accordance with access standards.

On October 27, 2022, a CAST representative contacted the member and provided three (3) INN provider options. Two (2) providers had appointment availability outside of applicable access standards, and one (1) provider had immediate appointment availability.

The CAST representative conducted additional outreach and identified a fourth INN provider with appointment availability on October 31, 2022, which met access requirements. The member was informed of all identified provider options to ensure compliance with Knox-Keene Act requirements related to access to care and informed choice.

LFC15: The member's mother contacted Customer Service to inquire about the non-minor member's ability to receive services from an out-of-network (OON) provider. At the time of the call, there was no documentation indicating that the member had requested assistance with locating in-network (INN) provider appointment options.

During the call, the Customer Service Representative (CSR) advised the member's mother that, because the member is a non-minor, Customer Service is unable to request or disclose INN provider appointment information without the member's verbal or written authorization, in accordance with applicable privacy and confidentiality requirements. The member's mother indicated that the member was not present during the call and was therefore unable to provide consent.

As authorization could not be obtained, no INN provider information was disclosed, and no appointment search or referral activity was initiated. The call was concluded in accordance with established Customer Service procedures and applicable privacy standards.

Specific to LFC13 file, individualized coaching will be provided to the Care Advocate involved to reinforce requirements related to assisting members with locating in-network (INN) providers who meet applicable access standards. This coaching will emphasize the Care Advocate's responsibility to actively support members in identifying available INN provider options and to clearly document all outreach and assistance provided.

In addition, the coaching will include education on the timely identification and facilitation of Single Case Agreement (SCA) requests when INN providers are unavailable within required access standards. Care Advocates will be reminded of the expectation to initiate and escalate SCA requests promptly

when warranted, to ensure uninterrupted access to covered services in accordance with Knox-Keene Act requirements. USBHP aims to complete coaching by February 18, 2026.

Specific to files, LFC_RP5, LFC_RP 12, LFC_RP 13, LFC_RP 17, LFC_RP 18, LFC_RP 19, LFC_RP 20, and LFC_RP 21, USBHP has implemented process enhancements to address the identified violations and strengthen compliance with applicable regulatory requirements.

Throughout calendar year 2024, these updates emphasize the accurate and complete inclusion of required information within case notes and Adverse Benefit Determination (ABD) letters.

Specifically, the Plan reinforced expectations that case documentation clearly reflects when appointments have been offered to enrollees, when appointments are available within applicable access standards, and when alternative provider options have been communicated to the enrollee.

Staff are required to document all outreach efforts, appointment availability, and any alternative provider offerings in a consistent and standardized manner to ensure a complete and auditable record.

These controls are designed to ensure that the Plan's records accurately demonstrate compliance and clearly substantiate that appointment access requirements have been met or that appropriate alternative arrangements have been offered to enrollees when necessary.

While the enhanced standards have been operationalized, USBHP has identified the need to formally update applicable internal guidance materials to fully document these requirements. Accordingly, USBHP will complete the necessary updates to its guidance materials and will conduct additional staff training to ensure awareness of and adherence to the updated requirements.
USBHP aims to complete the guidance material updates by February 15, 2026. Additionally, USBHP aims to complete training by February 18, 2026.

Supporting Documentation:
Violation 2_LFC9_SCA Review
Violation 2_LFC12_Appt Search Assistance

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with timely access requirements included in Sections 1367.03(a)(1), and (a)(5)(D), (E), 1368(a)(1) and (4), and Rule 1300.67.2.2(b)(2), and (c)(5)(D) and (E).

Violation 3:
The Plan fails to ensure USBHP consistently arranges for the timely provision of behavioral health care for the Plan's enrollees.

Conclusion:
Plan and USBHP documents, benefit coverage denial files, urgent appeal files and interviews demonstrated USBHP administratively denied out-of-network care and failed to offer, refer, or authorize the enrollee to receive in-network services within geographic and timely access standards. The Plan is failing to ensure USBHP is complying with timely access and SB 855 requirements and, therefore, the Department finds the Plan in violation of Sections 1367(d),

1367.03(a)(1) and (5)(A) – (F), 1367.03(c), 1374.72(a)(1) and (d), 1374.721(f)(3)(A) and Rule 1300.67.2.2(c)(1).

Plan Response:

USBHP
File Review
USBHC respectfully disputes the violation cited for case files LFF11 and LFF19.

The requests associated with LFF11 and LFF19 were administrative in nature and did not constitute requests for authorization of covered clinical services. Specifically, the members or their representatives requested consideration of a Single Case Agreement (SCA) with an out-of-network provider. An SCA is a contractual and administrative accommodation request rather than a utilization management (UM) decision involving medical necessity or benefit coverage.

In both cases, USBHCP conducted a comprehensive search for in-network (INN) facilities in compliance with applicable access-to-care standards. The access review confirmed the following:

- One or more in-network facilities met access requirements
- Identified in-network providers had immediate appointment availability
- No access deficiencies existed that would warrant out-of-network authorization via an SCA

Based on these violations, the requests did not meet USBHCP's established criteria for approval of a Single Case Agreement. The requests were therefore administratively denied, consistent with plan policies and access-to-care regulations.

These case files were selected for DMHC review from the Appeal file universe, not from the SCA (UM) processing workflow. As a result, the files initially submitted to DMHC did not include system screenshots or audit artifacts evidencing the internal SCA processing steps, including documentation of the in-network access search.

The absence of these screenshots in the appeal files should not be construed as a failure to conduct the required review but rather reflects the scope and structure of the appeal documentation retained in the system of record.

To address this concern and provide full transparency, additional documentation is being submitted with this rebuttal. This supplemental material includes evidence of the in-network provider search and confirms compliance with access-to-care requirements at the time of each request.

To reinforce and sustain compliance, Care Advocacy staff will receive refresher training on the administrative review process requirements. This training will emphasize the importance of confirming and offering INN provider options that meet access standard requirements prior to the issuance of an administrative denial. USBHP aims to complete staff training by February 16, 2026.

Specific to LFF17 file, USBHP will provide targeted coaching and training to the designated Knox-Keene Appeals Coordinators (ACs) on the complete process for researching and processing Administrative Appeals, including the requirements for identifying and addressing allegations involving access

standards and continuity/transition of care when concerns are raised within an Appeal and reinforce expectations for documentation, case analysis, and escalation procedures.

The targeted education will ensure consistent, accurate, and compliant processing of Administrative Appeals with particular focus on cases involving potential access or continuity-of-care elements. USBHP aims to complete staff training by February 16, 2026.

Specific to files LFF26, LFF29, LFF30, LFF32, LFF34, LFF35, LFF36 and LFF38, USBHP will complete the following action to improve and sustain compliance with Knox Keene requirements:

1. Education of Complaints Reviewer Team: Provide targeted training to all Complaints Reviewers on the required turnaround times (TAT) for non-urgent appointment offers. USBHP aims to complete staff training by March 15, 2026.

2. Strengthened Complaints team and Care Advocacy Coordination: Establish a consistent communication workflow between the Complaints Review team and Care Advocacy, defining clear handoff procedures for cases needing provider search support and ensuring timely provider identification for non-urgent cases. USBHP aims to complete staff training by March 01, 2026.

Outcome Measures:
Quarterly reports will be reviewed to verify that timely access standards for non-urgent appointment offers are consistently met. Compliance will be assessed by evaluating whether appointment offers are made within established turnaround times (TAT). Trends will be monitored for improvement or recurrence, and results will be documented.

Quarterly reports will be reviewed to ensure that all complaints related to provider directory inaccuracies are consistently identified, appropriately referred for investigation, and supported with complete documentation. The review will evaluate timeliness of referrals, accuracy of categorization, and adequacy of investigative follow-through. Trends will be analyzed to confirm improvement in the handling of directory-related complaints.

Sustained compliance over two consecutive quarters will indicate effective corrective action and process stability.

USBHP aims to complete staff training by March Targeted Quarterly Monitoring Completion: Q2 2026 (Q1 2026 review period).

Specific to LFB_BH2, LFB_BH3, LFB_BH5, LFB_BH9, LFB_BH12, LFB_BH13 and LFB_BH15 files, USBHP has implemented process enhancements to address the identified violations and strengthen compliance with applicable regulatory requirements.

Throughout calendar year 2024, these updates emphasize the accurate and complete inclusion of required information within case notes and Adverse Benefit Determination (ABD) letters.

Specifically, the Plan reinforced expectations that case documentation clearly reflects when appointments have been offered to enrollees, when appointments are available within applicable access standards, and when alternative provider options have been communicated to the enrollee.

Staff are required to document all outreach efforts, appointment availability, and any alternative provider offerings in a consistent and standardized manner to ensure a complete and auditable record.

These controls are designed to ensure that the Plan's records accurately demonstrate compliance and clearly substantiate that appointment access requirements have been met or that appropriate alternative arrangements have been offered to enrollees when necessary.

While the enhanced standards have been operationalized, USBHP has identified the need to formally update applicable internal guidance materials to fully document these requirements. Accordingly, USBHP will complete the necessary updates to its guidance materials and will conduct additional staff training to ensure awareness of and adherence to the updated requirements.

Administrative denial reports will be reviewed on a monthly basis to ensure compliance with the requirement to offer in-network (INN) provider options prior to the issuance of an administrative denial. When opportunities for improvement are identified, individualized staff coaching and/or additional Care Advocacy Team training will be provided. USBHP aims to implement monthly monitoring March 15, 2026.

UHC of California

Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with timely access and SB 855 requirements included in Sections 1367(d), 1367.03(a)(1) and (5)(A) – (F), 1367.03(c), 1374.72(a)(1) and (d), 1374.721(f)(3)(A) and Rule 1300.67.2.2(c)(1).

Supporting Documentation:

Violation 3_LFF11_INN Prov Options_SCA
Violation 3_LFF19_INN Prov Options_SCA
Violation 3_Updated ABD Ltr Template_0924

Utilization Management, including Triage and Screening

Violation 4:
The Plan fails to ensure USBHP's post-stabilization care process meets Knox-Keene Act requirements.

Conclusion:
Plan and USBHP documents and repeat caller files demonstrated that USBHP is failing to timely authorize post-stabilization care and is requiring hospitals to make more than one phone call to obtain authorization of post-stabilization care. The Plan is failing to ensure USBHP is complying with post-stabilization authorization requirements and, therefore, the Department finds the Plan in violation of Sections 1262.8(b)(2)(B), (d)(1)(A), (d)(1)(B), (d)(2), 1371.4(j)(1), (j)(2) and (j)(3), and Rule 1300.71.4(b)(1), (b)(2) and (c).

Plan Response:

USBHP
USBHP respectfully disputes the examiner's conclusion that this case failed to meet Knox-Keene requirements for post-stabilization care.

On July 22, 2022, at 12:42 p.m., the facility contacted USBHP to notify the Plan of an inpatient admission that had occurred the prior day. The caller was documented as a facility representative. During this call:

- The facility did not request prior authorization for post-stabilization care
- No clinical information was provided
- No clinical information was requested
- The caller stated that a clinician would call back to request prior authorization, if needed

This contact constituted a notification only, not a request for authorization.

Notwithstanding the lack of an authorization request during the initial notification call, USBHP subsequently approved the inpatient stay, and all related claims were paid in accordance with applicable benefits and regulatory requirements. At no point did the Plan deny or delay medically necessary post-stabilization care.

USBHP respectfully disagrees with the examiner's conclusion that the Plan's AB 1203 Notice is deficient or non-compliant.

Assembly Bill 1203 requires health care service plans to provide non-contracting hospitals with a telephone number that may be used to request authorization for post-stabilization care, ensuring prompt access to persons authorized to facilitate such requests. The statute requires that the number provide timely and effective access to the Plan for post-stabilization authorization purposes.

The telephone number listed in USBHP's AB 1203 Notice, 1-800-999-9585, is appropriate, compliant, and consistent with regulatory expectations. This number is the Plan's designated, monitored, and continuously available access point for authorization-related inquiries, including post-stabilization care requests initiated by out-of-network providers.

Key attributes of the number include:

- 24 hours per day / 7 days per week availability
- Answers by trained individuals capable of addressing urgent authorization inquiries
- Ability to immediately facilitate authorization requests, including:
- Direct handling of post-stabilization authorization questions
- Warm transfer to a live clinical reviewer or care advocate, when applicable
- No reliance on voicemail, call-back queues, or automated delays for urgent authorization needs

As such, the number fully satisfies the requirement under AB 1203.

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with post-stabilization authorization requirements included in Sections 1262.8(b)(2)(B), (d)(1)(A), (d)(1)(B), (d)(2), 1371.4(j)(1), (j)(2) and (j)(3), and Rule 1300.71.4(b)(1), (b)(2) and (c).

Supporting Documentation:
Violation 4_LFC29_Auth and Clms Paid

Violation 5:
The Plan fails to ensure USBHP consistently and adequately monitors trends in over and under-utilization of behavioral health care services.

Conclusion:
Plan and USBHP documents demonstrated that USBHP does not have a sufficient process for continuously reviewing utilization of services and facilities and does not monitor whether the provision and utilization of behavioral health services meet professionally recognized standards of practice because USBHP does not effectively track over and under-utilization of services. The Plan is failing to ensure USBHP is monitoring the utilization of behavioral health services and, therefore, the Department finds the Plan in violation of Section 1367.01(j) and Rules 1300.70(a)(1) and (3) and 1300.70(c).

Plan Response:

USBHP
On January 26, 2026, USBHP submitted a factual error in response to this violation.

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with utilization of behavioral health services included in Section 1367.01(j) and Rules 1300.70(a)(1) and (3) and 1300.70(c).

Supporting Documentation:
01-26-26_UHCCA Response Factual Error Request - DMHC BHI Report

Grievances and Appeals

Violation 6:
The Plan fails to ensure USBHP is consistently and adequately considering all issues within enrollee grievances and providing rectification when appropriate.

Conclusion:
Plan and USBHP documents and grievance files demonstrated that USBHP does not adequately consider and rectify all issues within an enrollee's grievance. The Plan is failing to ensure USBHP is complying with grievance system requirements and, therefore, the Department finds the Plan in violation of Section 1368(a)(1) and Rule 1300.68(a)(4).

Plan Response:
USBHP
USBHP will complete the following action to improve and sustain compliance with Knox Keene requirements:

1. Education of Complaints Reviewer Team: Provide targeted training to all Complaints Reviewers on the required turnaround times (TAT) for non-urgent appointment offers. USBHP aims to complete staff training by March 15, 2026.

2. Strengthened Complaints team and Care Advocacy Coordination: Establish a consistent communication workflow between the Complaints Review team and Care Advocacy, defining clear handoff procedures for cases needing provider search support and ensuring timely provider identification for non-urgent cases. USBHP aims to enhance process development by March 1, 2026.

3. Provide targeted reeducation to the Complaint Reviewers on expectations for accurately identifying, reporting, and documenting provider directory inaccuracies to the Network Management/Provider RelationFs Advocate (PRA). USBHP aims to complete staff training by March 15, 2026.

Outcome Measures:
Quarterly reports will be reviewed to verify that timely access standards for non-urgent appointment offers are consistently met. Compliance will be assessed by evaluating whether appointment offers are made within established turnaround times (TAT). Trends will be monitored for improvement or recurrence, and results will be documented.

Quarterly reports will be reviewed to ensure that all complaints related to provider directory inaccuracies are consistently identified, appropriately referred for investigation, and supported with complete documentation. The review will evaluate timeliness of referrals, accuracy of categorization, and adequacy of investigative follow-through. Trends will be analyzed to confirm improvement in the handling of directory-related complaints.

Sustained compliance over two consecutive quarters will indicate effective corrective action and process stability.

USBHP aims to implement Quarterly monitoring in Q2 2026 for review period Q1 2026.

Supporting Documentation:
N/A

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with grievance system requirements included in Section 1368(a)(1) and Rule 1300.68(a)(4).

Violation 7:
The Plan fails to ensure USBHP's customer service staff consistently identify enrollee expressions of dissatisfaction as grievances.

Conclusion:
Plan and USBHP's documents, USBHP's call inquiry audio files, and information obtained during interviews demonstrated that USBHP did not consistently identify oral expressions of dissatisfaction as grievances in calls received from enrollees. The Plan is failing to ensure USBHP is complying with grievance system requirements and, therefore, the Department finds the Plan in violation of Section 1368(a)(1) and Rule 1300.68(a)(1).

Plan Response:

USBHP
USBHP is developing enhanced annual training for all relevant staff.
Key enhancements include:

- Clear definitions and regulatory requirements for grievances under Knox-Keene
- Step-by-step guidance on identifying member dissatisfaction in real-time interactions
- Practice-based scenarios demonstrating:
    - Verbal expressions of dissatisfaction
    - Implicit or indirect complaints
    - Requests that must be logged as grievances regardless of member intent
    - Instructions on documentation, escalation, and reporting protocols

Training content will be standardized and delivered annually, with required completion tracked and enforced.

USBHP aims to complete enhanced training development by March 15, 2026. Additionally, USBHP aims to complete staff training by March 31, 2026.

UHC of California
Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with grievance system requirements included in Section 1368(a)(1) and Rule 1300.68(a)(1).

Supporting Documentation:
N/A

Violation 8:
The Plan's website does not include information about accessing behavioral health care services and other Knox-Keene Act required information and fails to include a link to USBHP's website.

Conclusion:
Sections 1368.015(f)(1) and (2) and 1368.016(a) require the Plan's internet website to include specified information, including, but not limited to, how to access behavioral health care services and file a grievance. Compliance can be achieved if the Plan includes on its internet website a link to USBHP's internet website, and USBHP complies with the statutory requirements. However, the Plan's website neither included the statutorily required information nor a link to USBHP. Therefore, the Department finds the Plan in violation of the statutory requirements.

Plan Response:
The Plan has submitted updated, date-stamped screenshots documenting the complete end-to-end navigation path required to access the Optum Behavioral Health website, commencing with member login at www.myuhc.com. as part of the Plan's efforts to substantiate compliance with all relevant DMHC regulatory and audit obligations.

Supporting Documentation:
DEF_8_1_PathToOBH_UHCCA_BH

Quality Assurance

Violation 9:
The Plan fails to ensure USBHP's customer service staff are knowledgeable and competent regarding enrollee questions and concerns.

Conclusion:
Review of the USBHP's repeat caller inquiry files and audio calls demonstrated the CSRs were not consistently knowledgeable and competent regarding enrollee questions and concerns. The Plan is failing to ensure USBHP's customer service staff are knowledgeable and competent regarding enrollee questions and concerns and, therefore, the Department finds the Plan in violation of Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

Plan Response:

USBHP
With respect to the customer service representatives referenced in the Department's violations, USBHP confirms that appropriate action has been taken consistently with the Plan's policies and procedures. Specifically, the identified staff members either separated from employment prior to the initiation of corrective measures, were terminated following review, or were subject to corrective action and performance monitoring in accordance with established Plan protocols.

The Plan does not concede, nor does it agree, that the Department's observations are indicative of a systemic deficiency in USBHP's customer service operations or representative competency. Rather, the violations reflect the Department's review of a limited subset of cases and should be interpreted within that context.

USBHP maintains established policies, procedures, and training requirements designed to ensure that customer service representatives are able to knowledgeably and competently address enrollee inquiries in accordance with applicable regulatory and contractual standards. The Plan employs ongoing quality assurance activities, supervisory oversight, and call monitoring processes to promote consistent compliance with these requirements.

When the Plan identifies that a customer service representative has not adhered to standard protocols and/or procedures, USBHP follows defined corrective action processes. These processes include management review and investigation of the identified issue(s), direct follow-up with the staff member, targeted retraining and education as appropriate, and enhanced monitoring. Monitoring continues until the Plan determines that the individual has demonstrated sustained compliance and the ability to independently handle enrollee calls consistent with Plan standards.

USBHP remains committed to continuous oversight and quality improvement and to ensuring that enrollees receive accurate, timely, and compliant customer service. A copy of the Plan's relevant policies and procedures governing customer service performance management, corrective action, and monitoring is attached for the Department's review.

UHC of California

Refer to Violation #10 for the Plan's response demonstrating oversight to ensure USBHP's compliance with ensure USBHP's compliance with requirements in Section 1367.03(a)(10) and Rule 1300.67.2.2(c)(10).

Supporting Documentation:
Violation 9_USBHP_CS_Performance Review

Violation 10:
The Plan is acting at variance with its filed delegation agreements by failing to conduct adequate oversight of the behavioral health functions delegated to USBHP.

Conclusion:
The Plan is failing to monitor whether USBHP is providing required behavioral health care services to its enrollees. The delegation agreements between the Plan and USBHP specify that the Plan remains responsible for compliance with all applicable California laws and regulations and shall ensure that USBHP complies with all applicable California laws and regulations. However, the Plan is failing to conduct adequate oversight of the behavioral health functions delegated to USBHP and is therefore operating at variance with its filed delegation agreements and is subject to discipline under Section 1386(b)(1).

Plan Response:

The Plan affirms that the oversight elements identified by the Department, including those associated with Customer Service and Grievance functions, are already subject to active review within the Delegation Oversight Committee as part of the Plan's established governance and compliance oversight processes. As part of the corrective action process, the Plan will address the components within a 90-day corrective action timeframe. To ensure full alignment with statutory and regulatory requirements under the Delegation Agreement and the Knox Keene Act and its implementing regulations, the Plan will transition the identified reporting components into the formal reporting structure of the California Quality Improvement Committee (CA QIC). This enhancement will strengthen ongoing monitoring, evaluation, and documentation of required oversight activities and will support the Plan's compliance with applicable Health & Safety Code and Title 28 CCR requirements.

A. Provider Directory Functions (Violation #1)
   The Plan conducts an annual review of USBPH policies to ensure compliance with applicable regulatory requirements, including Sections 1367.27(e)(1), 1367.27(j)(3), 1367.27(o)(1), 1367.2(o)(2)(B), and 1367.27(n)(2). As part of this process, USBPH policies are incorporated into the Plan's Provider Directory Annual Filing Requirements and submitted through the required regulatory e-Filing process (e-Filing 20252236).

   To strengthen governance and oversight, the Plan will ensure that the results of this annual review, including confirmation of policy compliance and any identified gaps or updates, are formally presented on an annual basis to the California Access & Availability Workgroup. The Workgroup will review the information as part of its oversight responsibilities, and any determinations, recommendations, or follow-up actions will be documented to support ongoing monitoring, accountability, and sustained regulatory compliance.

Supporting Documentation:
DEF_1b._10.A._2026_CA_AAWG_Directory_Policy_Compliance_Tracker_USBPH
DEF_10._AAWG_02.03.2026

B. Appointment Availability and Timely Access (Violations # 2 & #3)
Effective April 2023, the Plan implemented and has maintained a formal oversight process whereby USBPH delivers quarterly presentations to the Access & Availability Workgroup on (i) Network Adequacy— aligned with the Knox-Keene Act and implementing regulations, including Health & Safety Code §§ 1367.03 and 1367.035, as well as the specific statutory obligations under Sections 1367.03(a)(1), 1367.03(a)(5)(D) and (E), and corresponding regulatory requirements under Title 28 CCR §§ 1300.67.2 and 1300.67.2.2, including Rule 1300.67.2.2(b)(2) and (c)(5)(D) and (E)—and (ii) Access-related Complaints, consistent with the Plan's grievance-system monitoring and quarterly reporting obligations under Title 28 CCR § 1300.68(f). These quarterly presentations serve as a structured governance mechanism to ensure ongoing monitoring, evaluation, and compliance with applicable network access requirements. These documents were previously submitted under the Quality Assurance Section (Titled: BHIQA9-10_AAWG_01.23, BHIQA9-10_AAWG_01.24, BHIQA9-10_AAWG_02.23, BHIQA9-10_AAWG_04.23, BHIQA9-10_AAWG_05.24, BHIQA9-10_AAWG_07.23, BHIQA9-10_AAWG_10.23) of the original audit for the Department's review. The Plan is resubmitting the materials, retitled for clarity, ease and alignment with the Department's documentation standards, under the following new names:

Supporting Documentation:
DEF_2._3._10._AAWG_01.23
DEF_2._3._10._AAWG_01.24
DEF_2._3._10._AAWG_02.23
DEF_2._3._10._AAWG_04.23
DEF_2._3._10._AAWG_05.24
DEF_2._3._10._AAWG_07.23
DEF_2._3._10._AAWG_10.23
DEF_2._3._10._AAWG_BH_AccessReport_UHCCA_2023-Q3.2025

C. Utilization Management (Violations #4 & #5)
The Plan respectfully disputes this finding as the Plan has described an adequate process to oversight UM functions delegated to USBHCPA consistent with the Master Agreement and Amendment Six. Moreover, interpretation of a contractual adequacy standard is a matter for the parties to the Master Agreement.

<u>Violation #4</u>
The Plan maintains an effective, independent oversight of USBHP's policies and procedures, and its administration of their delegated activities, to ensure full compliance with state requirements. The Plan conducts quarterly assessments and comprehensive annual assessments of the performance of USBHP's delegated functions by reviewing their policies and procedures as well as a random sampling of their case files. Within the policy and procedure review, the Plan validates the delegate remains compliant with post stabilization requirements by reviewing USBHP's documents that address Emergency care & post stabilization services which is shown in the evidence provided. The UHC Clinical Delegation Oversight assessment process addresses all health plan requirements, including ensuring the delegate has 24/7 phone line available to meet the requirements for 1262.8(b)(2)(B). If the Plan detects gaps in either USBHP's policies or case files,

then the Plan has a structured process to review the identified gaps with USBHP. The Plan will first work collaboratively to review the gaps with USBHCPA. If the time to close any gaps is extensive or if progress is not made to close the gaps, then the Plan may place a delegate such as USBHP on an improvement action plan to ensure that all gaps are appropriately remediated.

The United Clinical Services Clinical Delegation Oversight team conducts quarterly assessments of delegated entities, including comprehensive reviews of randomly selected case files. One of these quarterly assessments serves as the annual evaluation and incorporates an in-depth review of policies and procedures to ensure full regulatory compliance. When findings are identified, they are submitted to the Clinical Remediation team, which partners directly with the delegate to drive complete, accurate, and timely remediation. The template "Case File Review "reflects the information we collect and evaluate as part of our ongoing oversight process.

Supporting Documentation:
DPM Assessment Questions (See UMC69)
Case File Review
PCA-1-25-02619-Clinical-QRG_12042025
File Review Questions (See Question #4)

<u>Violation #5</u>
Over and underutilization is monitored through the Plan's policy and procedure review by asking how USBHP monitors and remediates over and underutilization of services to ensure there is evidence of goals, and analyses of results, which includes actions to reassess as needed. Additionally, the Plan collects semiannual reporting and USBHP's annual program evaluation.

The Plan exercises rigorous and independent oversight of the USBHP's policies, procedures, and the administration of its delegated responsibilities to ensure adherence to all applicable state regulatory requirements. This oversight framework includes structured quarterly evaluations by the Plan, as well as a comprehensive annual assessment of USBHP's delegated functions, encompassing a review of relevant policies and procedures as well as a systematic sampling of random case files. The Plan ensures that USBHC applies objective and evidence-based criteria to each member's clinical information in every case and takes the local delivery system into account regarding the appropriateness of the individual services. The Plan confirms that any denials based on lack of medical necessity are made by appropriate individual reviewers and are communicated to members in written letters that include appeal rights and appropriate state information as required.

Supporting Documentation:
DPM Assessment Questions (See OQ41 and OQ65)
PCA-1-25-02632-Clinical-QRG_12182025
2026_HICE_UM_Delegation_Report_Template

D. Grievance and Appeals (Violations #2, # 3, 6, and #7)
The Plan affirms that the oversight elements identified by the Department, including those associated with Customer Service and Grievance functions, are already subject to active review within the Delegation Oversight Committee as part of the Plan's established governance and compliance oversight processes. As part of the corrective action process, the Plan will address the components within a 90-day corrective action timeframe. To ensure full alignment with statutory and regulatory requirements under the Delegation Agreement and the Knox Keene Act and its implementing regulations, the Plan will transition the identified reporting components into the formal reporting structure of the California Quality

Improvement Committee (CA QIC). This enhancement will strengthen ongoing monitoring, evaluation, and documentation of required oversight activities and will support the Plan's compliance with applicable Health & Safety Code and Title 28 CCR requirements.

Supporting Documentation:
N/A

E. Customer Service (Violations #1, # 2, 3, 6, 7 and #8)
The Plan affirms that the oversight elements identified by the Department, including those associated with Customer Service and Grievance functions, are already subject to active review within the Delegation Oversight Committee as part of the Plan's established governance and compliance oversight processes. As part of the corrective action process, the Plan will address the components within a 90-day corrective action timeframe. To ensure full alignment with statutory and regulatory requirements under the Delegation Agreement and the Knox Keene Act and its implementing regulations, the Plan will transition the identified reporting components into the formal reporting structure of the California Quality Improvement Committee (CA QIC). This enhancement will strengthen ongoing monitoring, evaluation, and documentation of required oversight activities and will support the Plan's compliance with applicable Health & Safety Code and Title 28 CCR requirements.

Supporting Documentation:
N/A

F. SB 855 (Violation #3)
The Plan ensures that USBHP provides coverage and access to care for mental health services that are applied no more stringently than the services and access for general medical care both for quantitative treatment limitations and non-quantitative treatment limitations. Within the Plan's policy and procedure assessment, it is asked that the Delegate provide a process document that validates parity for mental health and substance use disorder according to state and federal regulations.

Supporting Documentation:
DPM Assessment Questions (See OQ41)
File Review Questions (See Question #5)
PCA-1-25-01530-Clinical-QRG_07162025

Violation 11:
The Plan failed to file its On-going Delegation Oversight policy and procedure with the Department.

Conclusion:
The Plan is required to file any changes to policies and procedures describing its internal review of the quality of health care within 30 days after implementing the change.160 The *On-going Delegation Oversight* procedure states that it was effective on January 17, 2019, and revised during the BHI review period on September 7, 2022. However, the Plan failed to file the procedure within 30 days after its effective date of January 18, 2019, or within 30 days after revising the procedure on September 7, 2022. Therefore, the Department finds the Plan in violation of Section 1351(m), 1352(a), and Rule 1300.52.4(b)(i)(A).

Plan Response:
The Plan filed its Ongoing Delegation Oversight Policy through the DMHC e-Filing system under submission number 20242499 in May 2024. The Plan is actively engaged with the Department to address and resolve comments received and will submit revisions as needed to ensure full compliance with DMHC requirements.

Supporting Documentation:
N/A

Barriers

Barrier 1:
Neither the Plan nor USBHP review Independent Medical Review (IMR) overturn data to track whether denials are creating unnecessary barriers for access to behavioral health care.

Plan Statement:

USBHP
USBHP respectfully disputes DMHC's Barrier Finding #1. The Plan maintains established processes to review, analyze, and utilize Independent Medical Review (IMR) outcomes as part of its ongoing quality assurance, utilization management oversight, and continuous quality improvement activities, consistent with the Knox Keene Health Care Service Plan Act of 1975 and applicable regulations governing grievance systems and medical necessity determinations.

USBHP currently conducts quarterly reporting and review of all cases submitted to external review through the Department's Independent Medical Review process, including those involving behavioral health services. These reviews are designed to ensure that medical necessity determinations align with applicable clinical criteria, regulatory standards, and the Plan's obligation to provide timely access to medically necessary covered services.

As part of these quarterly reviews, USBHP's interdisciplinary staff and licensed clinicians systematically evaluate IMR cases, including but not limited to the following elements:

- Final IMR outcome
- Whether the denial was upheld or overturned
- Root cause analysis of the underlying determination
- Specific services requested or at issue
- Applicable timelines, including determination and turnaround times
- Final clinical and regulatory rationale provided by the Department's IMR vendor in cases where the Plan's decision was overturned

This structured review process supports the Plan's compliance with Knox Keene requirements related to grievance system monitoring, utilization review integrity, and quality assurance.
Consistent with its quality improvement framework, USBHP uses IMR outcome data to identify potential trends, assess systemic issues, and evaluate whether any operational or clinical practices may create unintended barriers to access, including for behavioral health services.

Through these quarterly analyses, USBHP staff and clinicians assess:

- Whether certain service types, levels of care, or clinical presentations are disproportionately subject to external review
- Whether clinical criteria were appropriately selected and applied
- Whether there are opportunities to improve internal processes, communication, or documentation to better support timely access to medically necessary care

When trends are identified, USBHP evaluates whether further action is warranted to remove or mitigate potential barriers, in alignment with the Plan's obligations under the Knox Keene Act to ensure access, continuity of care, and medically necessary services.

Historically, when IMR reviews have identified specific issues—such as opportunities for improved application of clinical criteria or documentation, USBHP has implemented targeted corrective actions, including:

- Additional education and training for utilization management staff and clinicians
- Clarification or reinforcement of clinical review protocols
- Operational process improvements to support accurate and timely determinations

These corrective actions are incorporated into the Plan's continuous quality improvement activities and monitored for effectiveness over time.

In addition to individual case review, USBHP trends IMR submissions to assess whether particular services are consistently undergoing external review. When such patterns are observed, the Plan evaluates whether additional measures are needed to further support access to care, which may include:

- Additional provider recruitment or network development efforts
- Updates to operational workflows or utilization management processes
- Further review of staff training, use, and applicability of relevant clinical criteria

This approach ensures that IMR data is used not merely for case level resolution, but as a meaningful input into broader access, quality, and utilization management oversight.

For the foregoing reasons above, USBHP disputes DMHC's Barrier Finding #1. USBHP maintains that it does track, review, and analyze IMR overturn data and incorporates these findings into its quality assurance and continuous quality improvement activities, consistent with Knox Keene requirements. While the Plan remains committed to enhancing transparency and documentation of these processes, USBHP respectfully submits that it does not ignore IMR overturn data and does utilize such information to identify trends, implement corrective actions when appropriate, and support enrollee access to medically necessary behavioral health services.

Barrier 2:
USBHP does not track all single case agreement (SCA) requests to identify potential gaps in network coverage.

Plan Statement:

USBHP
USBHP respectfully disputes the Department's violation and appreciates the opportunity to clarify its processes related to the monitoring, analysis, and use of Single Case Agreement (SCA) data in support of compliance with the Knox-Keene Health Care Service Plan Act of 1975, including network adequacy, timely access, and quality assurance requirements.

Contrary to the Department's conclusion, USBHP does track Single Case Agreements as part of its ongoing efforts to ensure enrollee access to medically necessary covered services when in-network providers are not available within applicable geographic proximity and timely access standards, consistent with Health and Safety Code §1367.03 and associated regulations.

Specifically:

- USBHP tracks all SCA requests and negotiations with out-of-network providers as part of its utilization management and provider contracting processes
- Each SCA requires substantive negotiation related to reimbursement, scope of services, and continuity of care considerations, and these negotiations are documented and monitored by the Plan
- The Plan consistently engages with out-of-network providers who submit SCA requests to explore opportunities for broader participation in the Plan's provider network, in furtherance of improving network adequacy and reducing reliance on out-of-network arrangements

USBHP incorporates SCA-related data into its quarterly Access and Availability Work Group updates, which serves as an interdisciplinary forum to monitor enrollee access, trends in accommodations, and potential barriers to care. This SCA data is reviewed to determine whether there is an unusual or increased volume of SCAs or other access-related accommodations that may indicate emerging or localized network adequacy concerns.

As part of this process:

- Quarterly reporting evaluates the volume, type, and service categories associated with SCAs in conjunction with access complaints, appointment wait time data, and geographic access standards
- The Plan analyzes whether observed SCA patterns reflect isolated continuity-of-care situations, provider availability issues, or broader market-based challenges such as workforce shortages or provider contract reluctance
- Violations from this analysis inform targeted provider recruitment strategies, network expansion initiatives (including telehealth modalities), and prioritization of specialties or service levels for contracting outreach

Consistent with Knox-Keene quality assurance and continuous quality improvement requirements (Health and Safety Code §§1367 and 1368), the analysis of network gap measures—including SCA activity—is escalated through USBHP's governance structure:

- Results of quarterly Access and Availability Work Group reviews, including SCA-related observations, are funneled to the Plan's Service Quality Committee and Quality Improvement Committee
- These committees assess trends, evaluate the effectiveness of recruitment and contracting efforts, and determine whether corrective actions or process enhancements are warranted to ensure compliance with timely access and network adequacy standards
- This governance structure ensures that SCA data is not reviewed in isolation, but rather as part of the Plan's comprehensive quality monitoring and improvement framework

USBHP consistently and proactively reaches out to out-of-network providers who have engaged in SCAs to encourage participation as contracted network providers. This outreach includes review of contracting terms, market dynamics, and provider feedback, with the goal of strengthening the network, improving enrollee access, and minimizing the need for future SCAs where feasible.
The Plan recognizes that certain SCA requests—particularly for inpatient and residential levels of care—may reflect broader statewide or regional provider shortages rather than an absence of recruitment efforts. Nonetheless, USBHP uses SCA data alongside other access indicators to refine recruitment strategies and assess the potential outcomes of those efforts over time.

For those foregoing reasons above, USBHP disputes the Department's barrier Violation #2. USBHP maintains that it does track and monitor Single Case Agreements and incorporates SCA data into its access monitoring, provider recruitment, and quality improvement activities in alignment with Knox-Keene requirements. While the Plan remains committed to enhancing data integration and transparency as part of its ongoing compliance and quality improvement efforts, USBHP respectfully submits that its existing processes already support the identification and evaluation of potential network gaps and promote timely access to care for enrollees.

Barrier 3:
USBHP does not track and trend repeat callers to identify patterns and problems that enrollees may experience in accessing behavioral health care.

Plan Statement:

USBHP
USBHP asserts that the Plan remains committed to ensuring timely access to medically necessary behavioral health services, effective operation of the grievance system, and robust quality assurance and continuous quality improvement in alignment with the Knox Keene Health Care Service Plan Act of 1975 and implementing regulations.

While USBHP does not currently track and trend "repeat callers" as a distinct metric within the telephony platform, the Plan emphasizes that it actively audits and monitors customer service operations to ensure that enrollee concerns, needs, and expressions of dissatisfaction are addressed accurately, appropriately, and timely, and that potential systemic access barriers are identified and remediated.

To evaluate and improve the effectiveness of customer service operations and the enrollee experience, USBHP maintains the following controls:

- Structured Call Handling Audits: Supervisors and team leaders conduct weekly audits of customer service representatives (CSRs) to confirm adherence to established policies and procedures, including appropriate escalation, documentation, and resolution protocols for access related issues
- Performance Management and Corrective Action: Where audit findings indicate patterns or performance concerns, team leaders implement targeted education and training, performance improvement plans, and, when necessary, disciplinary actions up to termination
- Cross Functional Escalation: If a pattern suggests issues beyond CSR performance—such as provider availability, referral pathways, or authorization workflows—team leaders escalate to the appropriate operational teams for further review, investigation, and remediation, ensuring that potential timely access or network adequacy issues are promptly addressed
- Issue Resolution Focus: Even without a discrete "repeat caller" trending module, call audits prioritize confirmation that first call resolution or documented follow up occurred, and that member reported barriers (e.g., locating in network providers, obtaining referrals) are routed to the correct access/availability or utilization management pathways

These oversight mechanisms are integrated into the Plan's Access & Availability and Quality Improvement governance, supporting monitoring, trend identification, and corrective actions consistent with Knox Keene's quality assurance requirements.

USBHP's existing audit and escalation framework is designed to flag and address patterns that may signal systemic problems, including, but not limited to, difficulties in locating in network providers, delays in referrals or authorizations, or breakdowns in member navigation. When such trends are identified, USBHP coordinates targeted interventions, which may include:

- Operational enhancements to referral and navigation workflows;
- Targeted provider recruitment or contracting outreach in areas showing access pressure;
- Timely access remediation, such as expedited appointments or alternatives; and
- Policy/process refinements and staff training to ensure consistent, member-centric resolution

Findings and interventions are shared through the Plan's Service Quality and Quality Improvement committees for oversight and continuous quality improvement.

To further strengthen compliance with the spirit of Knox Keene's monitoring and systemic issue detection, USBHP is in the process of transitioning to a new telephony system that will enable the Plan to systematically identify, track, and trend repeat callers and their issues on a routine basis. This enhancement will:

- Provide automated repeat caller identification at the member level;
- Enable issue type categorization and trend reporting (e.g., provider availability, referral delays, appointment scheduling barriers);
- Improve closed loop follow up and escalation tracking; and
- Augment existing Quality Assurance (QA) audits with data driven trend detection and early warning for potential access issues

USBHP anticipates completing this transition before the end of 2027. In the interim, the Plan will continue to rely on its weekly QA audits, cross functional escalations, and corrective action processes to identify and address patterns related to enrollee access and customer service effectiveness.

In conclusion, USBHP respectfully submits that, although a discrete repeat caller trending metric is not yet available within the current telephony platform, the Plan has instituted robust oversight, auditing, escalation, and corrective action processes to ensure timely access, effective grievance system operations, and continuous quality improvement in accordance with Knox Keene principles. The forthcoming telephony upgrade will further enhance the Plan's capability to identify, trend, and remediate repeat caller issues and potential systemic barriers, thereby strengthening enrollee access to appropriate in network behavioral health care.

USBHP remains committed to transparency, consumer protection, and ongoing improvement of its monitoring systems to support timely, medically necessary behavioral health services for all enrollees.

Barrier 4:
USBHP's standard fee schedule may create a barrier to increasing and retaining the number of in-network behavioral health care providers sufficient to meet the needs of the Plan's enrollees.

Plan Statement:

USBHP
USBHP asserts that the Plan remains firmly committed to meeting its obligations under the Knox Keene Health Care Service Plan Act of 1975 and applicable regulations to ensure timely access, network adequacy, and coverage of medically necessary behavioral health services. USBHP respectfully submits that its payment methodologies comply with Knox Keene's fair claims payment standards and that the Plan continuously evaluates reimbursement practices as part of its quality improvement and network development programs to support enrollee access to in network providers.

USBHP adheres to the requirements of 28 CCR §1300.71 regarding fair, fast, and accurate claims payment and the establishment of reasonable and customary payments for non-contracted professional services. USBHP utilizes the methodology commonly referred to as the "Gould criteria" (see 28 CCR §1300.71(a)(3)(B)) to determine usual, customary, and reasonable (UCR) rates for reimbursing non contracted providers, taking into account:

- The complexity and nature of the services rendered;
- The provider's training, qualifications, and length of time in practice;
- The prevailing rates for the geographic area;
- The applicable CPT/HCPCS coding and billing standards; and
- Any extenuating circumstances reflected in the medical record and claim submission

This framework is intended to ensure that payments are reasonable and consistent with regulatory standards, while the Plan concurrently works to recruit, contract, and retain in network providers to reduce reliance on UCR determinations.

USBHP also complies with AB 72 and the implementing Knox Keene provisions governing out of network services rendered at contracted facilities, including applicable requirements under Health & Safety Code §§1371.9 and 1371.31 and 28 CCR §1300.71.31. Where AB 72 applies, USBHP follows the required statutory payment methodologies and dispute resolution processes for non-contracted clinicians furnishing services at in network facilities, consistent with surprise billing protections and enrollee cost sharing limits.

Consistent with Knox Keene quality assurance and continuous quality improvement requirements, USBHP evaluates provider satisfaction feedback, network adequacy metrics, timely access data, and utilization patterns to inform reimbursement strategy and targeted contracting. This includes:

- Quarterly and annual reviews of fee schedules and market benchmarks to assess competitiveness by specialty, level of care, and geography;
- Clinician feedback loops via provider surveys and direct engagement to identify operational enhancements (e.g., claims processes, documentation support, and education);
- Targeted rate adjustments and contracting incentives where data indicate that reimbursement may be a contributing factor to localized or specialty specific access pressure; and
- Use of single case agreements, tele behavioral health expansion, and focused recruitment to address short term access needs while longer term contracting efforts are underway

In 2023, the Plan implemented negotiated reimbursement changes in select behavioral health categories and geographies as part of its ongoing network development strategy. While provider satisfaction rates may reflect broader market dynamics and workforce constraints, the Plan uses those inputs to prioritize contracting outreach and rate reviews in alignment with timely access standards and network adequacy obligations.

USBHP reimbursement levels are one of multiple variables influencing provider participation—alongside administrative simplicity, claims accuracy and timeliness, clinical integration, practice capacity, and local market conditions. The Plan's approach is to address these drivers holistically:

- Payment policy transparency and education to reduce administrative friction;
- Streamlined claims operations aligned to 28 CCR §1300.71 timeliness and accuracy standards;
- Use of data driven recruitment to add inpatient, residential, and intensive outpatient capacity where indicated by access metrics; and
- Ongoing evaluation of rate adequacy using Gould/UCR benchmarks for non-contracted claims and AB 72 methodologies where applicable

In parallel with the Plan's grievance and appeals framework (H&S Code §1368 and 28 CCR §1300.68), USBHP tracks and trends provider complaints and contracting feedback related to reimbursement. Identified patterns are elevated through the Plan's Access & Availability and Quality Improvement committees for further analysis and, where appropriate, corrective action, including targeted rate negotiations and contract amendments.

In conclusion, USBHP respectfully disputes the Department's Barrier Finding #4. USBHP maintains that it adheres to Knox Keene payment standards, including the Gould criteria under 28 CCR §1300.71(a)(3)(B) for usual and customary determinations, and complies with AB 72 requirements for non-contracted clinicians at in network facilities (H&S Code §§1371.9, 1371.31; 28 CCR §1300.71.31). The Plan continuously evaluates reimbursement strategy alongside network adequacy, timely access, and quality improvement data and has implemented targeted reimbursement and contracting interventions to support enrollee access to in network behavioral health providers.

USBHP remains committed to collaborative provider engagement, transparent payment practices, and ongoing market responsive adjustments to strengthen network capacity and ensure timely, medically necessary behavioral health services for all enrollees.

Barrier 5:
Pre-payment and post-payment audits by the USBHP's Payment Network Integrity (PNI) unit may discourage providers from accepting Plan enrollees.

Plan Statement:

USBHP
USBHP respectfully disagrees with the Department's conclusion that its Program & Network Integrity (PNI) pre-payment and post-payment audit activities constitute a barrier to provider participation or enrollee access to behavioral health services. The Plan maintains that these activities are legally required, narrowly scoped, and essential to consumer protection, and are conducted in full compliance with the Knox-Keene Health Care Service Plan Act of 1975, including Health and Safety Code section 1348.

Health care fraud is a crime under both state and federal law. Under Health and Safety Code section 1348(a), every health care service plan licensed to operate in California is required to establish and maintain a comprehensive anti-fraud plan. The purpose of this statutory mandate is to protect enrollees, providers, and the health care delivery system by ensuring the timely detection, investigation, and prosecution of suspected fraud, waste, and abuse (FWA).

In compliance with this statutory obligation, USBHP maintains an anti-fraud program that includes:
- Designation of individuals and entities with specialized investigative expertise
- Training of plan personnel and contractors in the detection of health care fraud
- Procedures for managing, investigating, and documenting suspected fraud
- Processes for referring confirmed violations to appropriate government agencies

PNI's pre-payment and post-payment audits are a core component of this legally mandated antifraud framework.

PNI's pre-payment and post-payment reviews are administrative audits of billed claims conducted solely for the purpose of identifying suspected fraud, waste, or abuse. These audits:
- Do not evaluate medical necessity, clinical appropriateness, or quality of care
- Do not substitute for utilization management or quality review functions
- Are limited to assessing whether billed services are supported by adequate documentation and comply with applicable billing guidelines

Audits are initiated only after services have been rendered and are triggered by specific tips or referrals alleging potential fraud, waste, or abuse. These tips may originate from members, provider staff, health plan personnel, or healthcare oversight agencies. Under applicable law and contractual obligations, PNI is required to review and validate all such tips. Failure to investigate credible allegations or interference with such investigations could constitute a violation of law.

Claims subject to PNI review are only denied or adjusted when:
- The provider fails to submit requested medical record documentation to support the billed service; or
- The submitted documentation does not meet established billing requirements for the service billed

In these circumstances, the determination is that the service was not properly documented or billed, which under applicable standards is deemed a failure to properly render the service for reimbursement purposes. These determinations are administrative and billing-based, not clinical judgments regarding the appropriateness of care.

USBHP's PNI processes incorporate procedural safeguards and provider due process, consistent with Knox-Keene principles of fairness and transparency. All overpayment demand letters issued by PNI include:

- Clear information on how to request reconsideration or dispute audit violations
- Instructions for submitting additional documentation
- Information on how to request provider-specific education tailored to the audit violations

These processes are designed to support compliance, promote accurate billing, and reduce future audit issues, rather than to penalize or discourage providers from participating in the network.

USBHP does not agree that its antifraud activities create barriers to network participation or enrollee access. Rather, PNI audits are conducted to protect the integrity of Plan assets and ensure that premium dollars are used appropriately to support medically necessary covered services for all enrollees. Fraudulently rendered behavioral healthcare services put vulnerable enrollees at risk of serious, life-threatening harm.

Down-coding by providers to avoid audits, as described in interviews, is not a Plan directive or expectation and is inconsistent with accurate billing practices. Providers are expected to bill for services actually rendered and properly documented. The Plan's antifraud obligations cannot be waived or curtailed based on provider perceptions of enforcement activities.

Moreover, failure to conduct FWA audits would prevent USBHP and PNI from fulfilling their legal and contractual obligations, including mandatory reporting of confirmed fraud, waste, and abuse violations to appropriate state regulatory agencies, which would itself constitute a violation of law and would leave vulnerable members without any protection from provider fraud or abuse.

USBHP maintains that its PNI pre-payment and post-payment audits are required by statute, limited in scope, and essential to consumer protection, and are not intended to discourage provider participation or restrict enrollee access to behavioral health services. These activities are conducted in accordance with Health and Safety Code section 1348 and the Knox-Keene Act's overarching goals of safeguarding enrollees, ensuring fiscal integrity, and maintaining trust in the delivery of health care services.
The Plan remains committed to ongoing provider education, transparency, and collaboration while continuing to meet its legal obligation to detect, investigate, and report suspected fraud, waste, and abuse.