BOARD OF SUPERVISORS

MEMORANDUM

RECEIVED
2023 OCT 24 PM 4:32
CLERK OF THE BOARD
COUNTY OF ORANGE
BOARD OF SUPERVISORS

10/24/23

To: Clerk of the Board

From: Supervisor Doug Chaffee, Fourth District
Supervisor Vicente Sarmiento, Second District

Subject: Supplemental Agenda Resolution Item for October 31, 2023 Board of Supervisors Meeting – Resolution to Oppose Kaiser Permanente's Attempt to Reduce Mental Health Therapists' Patient Management Time (PMT)

S23A

Supervisor Doug Chaffee and Supervisor Vicente Sarmiento respectfully request the Clerk of the Board to add a resolution item to the agenda for the October 31 Board of Supervisors meeting to "Oppose Kaiser Permanente's attempt to reduce mental health therapists' Patient Management Time (PMT)."

Resolution to "Oppose Kaiser Permanente's Attempt to Reduce Mental Health Therapists' Patient Management Time"

By the authority of the Orange County Board of Supervisors, the following resolution is hereby issued:

WHEREAS, Kaiser Permanente is one of the largest private providers of mental health care for Orange County residents, as well as County employees and their families; and

WHEREAS, the California Health Care Foundation reported that nearly 1 in 7 California adults experiences a mental illness, and the American Academy of Child and American Academy of Pediatrics declared a national emergency over a "shocking" rise in families seeking urgent mental help; and

WHEREAS, quality mental healthcare requires that therapists have sufficient time to chart appointments, communicate with social service agencies, or respond to patient correspondence known as Patient Management Time (PMT); and

WHEREAS, Northern Californian therapists at Kaiser Permanente are given seven hours per week for PMT, and current therapists in Orange County are permitted just three hours to perform the same duties; and

WHEREAS, Kaiser management in Orange County is proposing to raise the permitted PMT to only four hours for therapists who have unrealistically low appointment cancellation rates; and

WHEREAS, outside of Orange County, Kaiser Permanente is seeking to unilaterally cut the amount of permitted PMT for therapists to as few as two hours per week, which will make it increasingly difficult for Kaiser to comply with SB 221, requiring all health plans to provide follow-up therapy appointments within 10 business days unless the treating therapist determines that a longer wait would not be detrimental; and

WHEREAS, a reduction in protected PMT hours will worsen the equity gap in care that Kaiser Permanente mental healthcare patients in Southern California receive compared to Kaiser Permanente patients in Northern California; and

WHEREAS, non-English proficient speakers who require additional follow-up communication and patients who are children will be most impacted by the reduction in PMT, as their therapists need additional time to communicate with parents, teachers, and social workers; and

WHEREAS, Kaiser Permanente is increasing health plan rates by 10 percent or more for patients in Orange County; and

WHEREAS, on October 12, 2023, Kaiser Permanente entered into a $200-million settlement agreement with the California Department of Managed Health Care (DMHC), that includes paying a $50-million fine and pledging $150-million over 5 years to improve its behavioral healthcare services and promises to improve documentation of its patients' medical record; and

NOW, THEREFORE, BE IT RESOLVED that the Orange County Board of Supervisors opposes any unilateral action by Kaiser Permanente that reduces the amount of PMT time for therapists and calls for Kaiser Permanente to provide therapists in Southern California with the same amount of protected PMT that therapists in Northern California receive.

SONIA R. FERNANDES
Deputy Director | Chief Counsel, Bar Number 232932
ANGELA M. LAI
Assistant Chief Counsel, Bar Number 237616
LICIA M. MARSHALL
Attorney IV, Bar Number 265826
AMIR J. JAVIDEYAN
Attorney III, Bar Number 277636
CALIFORNIA DEPARTMENT OF
MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814-2725
916-323-0435 – Phone
916-323-0438 – Fax

Attorneys for the Department of Managed Health Care

BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

In the Matter of the Investigation of: Kaiser Foundation Health Plan, Inc., Respondent.	Enforcement Matter Number: 22-469; 2022 Non-Routine Survey 933-0055 **SETTLEMENT AGREEMENT**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled Enforcement Matters that the following matters are true:

PARTIES

The parties to this Settlement Agreement and Order of the Director of the Department of Managed Health Care ("Settlement Agreement") are:

1. Sonia R. Fernandes ("Complainant") is the Deputy Director and Chief Counsel of the DEPARTMENT OF MANAGED HEALTH CARE's ("Department") Office of Enforcement. Pursuant to Government Code section 11180 et seq., the Department's Director has delegated to Complainant the powers and authority to conduct the Department's investigations and enforcement matters. The enforcement investigations referred to herein were brought solely in Complainant's official capacity.

2. Kaiser Foundation Health Plan, Inc., ("Plan") was issued license number 933 0055 to operate a health care service plan on or about November 4, 1977. The Plan is represented in this matter by Sheppard, Mullin, Richter & Hampton, LLP.

3. The Department and the Plan are each referred to herein as a "Party," and collectively, as the "Parties."

ACTIONS

4. On May 16, 2022, the Department issued a notice, referenced as "License #933-0055," to the Plan of the Department's intent to conduct a non-routine survey of the Plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (the "Knox-Keene Act"), and regulations promulgated thereunder [1] (Health & Saf. Code, § 1382; Cal. Code Regs., tit. 28, § 1300.82.1) (the "2022 Non-Routine Survey").

5. On August 12, 2022, the Department initiated Enforcement Matter 22-469, titled In the Matter of the Investigation and Examination of: Kaiser Foundation Health Plan, Inc. (the "Enforcement Investigation").

6. The Parties desire to fully and finally resolve the 2022 Non-Routine Survey and the Enforcement Investigation, the terms and conditions of which are fully set forth in detail in this Settlement Agreement. The Department's investigation in connection with the 2022 Non-Routine Survey is ongoing. Notwithstanding, the Parties agree that this Settlement Agreement will resolve these matters, including penalties and any possible future enforcement referral that may arise related to deficiencies identified by the Department in the 2022 Non-Routine Survey Final Report, where the violation occurred prior to the date this Settlement Agreement is executed by all Parties.

ADVISEMENTS AND WAIVERS

7. The Plan has carefully read, fully discussed with counsel, and understands the

---

[1] The Knox-Keene Act 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.

effects of this Settlement Agreement.

8. The Plan is fully aware of its legal rights in this matter, including the right to a hearing on any potential accusation related to the Enforcement Investigation and 2022 Non-Routine Survey findings; the right to be represented by counsel at its own expense; the right to confront and cross-examine the witnesses against it; the right to present evidence and testimony on its behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; the right to require the Department to meet its burden of proof to establish all elements of any violations charged at an administrative or other hearing; and, all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Except as provided herein, by entering into this Settlement Agreement, the Plan voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above with respect to the Enforcement Investigation and 2022 Non-Routine Survey.

10. The Plan acknowledges that this Settlement Agreement will be posted on the Department's public website and will be public record. For work product created under this Settlement Agreement that is submitted to the Department, including portions of the Corrective Action Work Plan, the Plan may request confidential treatment pursuant to California Code of Regulations, title 28, section 1007, subdivision (a).

11. The Plan acknowledges that the Department's investigation in connection with the 2022 Non-Routine Survey is ongoing, and no Preliminary Report has been issued at the time of the Settlement Agreement. The Plan further acknowledges that the Department shall issue a Non-Routine Final Report upon completion of the 2022 Non-Routine Survey.

12. The Plan acknowledges that the Department may, as permitted by law, take into consideration deficiencies found by the 2022 Non-Routine Survey and/or documented in the 2022 Non-Routine Survey Final Report when assessing future administrative or other penalties under Section 1386 and Rule 1300.86.

13. The Parties agree that if the Plan discovers that it is in breach of any of its

obligations under this Settlement Agreement, it will promptly notify the Department in writing of the breach and what actions the Plan has taken or will undertake to cure the breach.

14. The Settlement Agreement may not be altered, amended, or otherwise changed or modified, except as provided herein or in writing signed by both of the Parties.

15. For purposes of construction, the language of the Settlement Agreement is to be construed broadly with respect to the nature and scope of the Department's oversight of the Plan and the Plan's obligations under the Settlement Agreement.

BACKGROUND AND HISTORY

16. The Plan is a full-service health care service plan licensed to operate in the State of California. As of December 31, 2022, the Plan had 9,056,931 enrollees in 32 of the 58 counties in California, making it the largest health care service plan by enrollees in the State. As of December 31, 2022, the Plan reported a total year revenue of $91,367,748,000, tangible net equity of $58,380,824,000, and cash equivalents of $717,781,000.

17. The Plan provides medical and hospital services to its enrollees in California through Kaiser Foundation Hospitals, Inc., ("KFH") and two medical groups, The Permanente Medical Group, Inc. and Southern California Permanente Medical Group (each a "Medical Group" and together the "Medical Groups"), that cover the Northern California market and the Southern California market, respectively. The Plan's long history of coordinated care has, and continues to, provide significant benefits to its enrollees. However, the Department has repeatedly cited the Plan for deficiencies in its oversight of the Medical Groups. While the Plan has not delegated its quality oversight obligations to the Medical Groups, the Plan has failed to clearly define the Medical Groups' roles related to the provision of behavioral health services and there is a lack of role clarity between the Plan and the Medical Groups. In part because of this lack of role clarity, the Plan has exercised inconsistent oversight over the Medical Groups and has not always intervened when necessary to ensure compliance. It is the Department's observation that the close coordination between the Plan and the Medical Groups contributes to the Plan's inconsistent oversight of the Medical Groups. To address these and other issues

identified by the Department, the Plan must, among other requirements, have continuous access to data, have full transparency to assess performance, and be fully engaged to take action or intervene where necessary to ensure compliance. However, the Plan is ultimately responsible for ensuring that compliant medical and behavioral health care services are provided to Plan enrollees.

18. Since 2006, the Department has brought several enforcement actions against the Plan for failure to consistently oversee the Medical Groups and ensure quality assurance compliance relating to the provision of medical and, most significantly, behavioral health care services. A history of these enforcement actions includes the following:

19. In March of 2006, the Department's Non-Routine Survey of the Plan's provision of renal transplant and related services to Plan enrollees at the renal transplant center at KFH – San Francisco (the "Transplant Center") and the Plan's oversight of the Transplant Center and The Permanente Medical Group, identified the Plan's deficiencies in the following areas: 1) Failure to provide oversight of the Medical Group in the administration of its kidney transplant program; 2) Failure to ensure that the Medical Group had sufficient administrative capacity to transfer enrollees from externally contracted kidney transplant centers into the medical group's kidney transplant program; 3) Failure to ensure that the Medical Group consistently provided timely accessibility to medically required specialists in its kidney transplant program; 4) Failure to ensure that the Medical Group utilized a formal system for handling and processing member grievances; and 5) Failure to ensure that specialty services related to kidney transplantation were provided in a manner providing continuity of care and ready referral of patients. In response to these findings, the Plan instituted corrective actions to address the issues identified related to the Plan's kidney transplant program.

20. On August 9, 2006, the Plan entered into a Consent Agreement where the Plan agreed to pay a penalty of $2 million and make a charitable donation of $3 million for the benefit of Donate Life California via the Eastbay Community Foundation. The Plan also agreed to ensure continuity of care for patients and ensure ready access to medical services for

enrollees.

21. In 2007, the Department's 2006 Non-Routine Medical Survey pertaining to the Plan's quality oversight program, identified the Plan's deficiencies in the following areas: 1) Failure to establish a program to monitor and evaluate the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice; 2) Failure to inform each delegate of the scope of that delegate's Quality Assurance ("QA") responsibilities and how it will be monitored by the Plan or have ongoing oversight procedures in place to ensure that delegates are fulfilling all delegated QA responsibilities; 3) Failure to ensure QA reports to the Plan's governing body from quality committees, to which it delegates QA responsibilities, are sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components that the QA program has identified as presenting significant or chronic quality of care issues; 4) Peer Review system is not designed to ensure the level of care meets professional recognized standards of practice and not effective to identify and correct deficiencies in care; and 5) QA system is not designed to ensure a level of care meeting professionally recognized standards of practice is delivered to all enrollees and not effective to identify and correct deficiencies in care.

22. On July 30, 2007, the Plan entered into a Consent Agreement where the Plan agreed to pay a penalty of $2 million and implement a corrective action plan which included changes to the Plan's reporting process to allow the Plan to better monitor the health care delivery system at the medical center level, implementation of a Peer Review Performance Project and regular audits of the Plan's medical centers to ensure a uniform set of peer review standards and consistency throughout the clinical departments, correction of Potential Quality Issues (PQI), and implementation of program changes at the facility level.

23. In 2013, the Department's 2012 Routine Survey identified deficiencies related to the ability of the Plan to provide enrollees with timely access to mental health appointments. Specifically, the Plan: (1) failed to accurately measure behavioral health appointments based

in part on some medical centers and facilities ability to customize the Plan's Patient Appointment Registration Reporting System (PARRS) beyond established Plan policies and procedures; (2) failed to monitor appointment wait times, hindering the Plan's ability to detect patterns of non-compliant wait times and leading to inaccurate compliance reports; (3) failed to resolve access deficiencies through its QA Program and instead shifting responsibility onto the medical center and/or the medical group's clinical and administrative management to establish and implement corrective actions; and (4) failed to provide accurate and understandable effective behavioral health education services.

24. On June 24, 2013, the Department filed an Accusation and a Cease and Desist Order based on the deficiencies identified in the 2013 Routine Survey Final Report, seeking an administrative penalty of $4 million. In September of 2014, the Plan agreed to pay an administrative penalty of $4 million.

25. In 2015, the Department's Follow-Up Survey identified two uncorrected deficiencies. Specifically, the Plan's Behavioral Health Quality Assurance Program failed to ensure that effective corrective action was taken when deficiencies were identified, and the Plan failed to provide accurate and understandable behavioral health benefit and coverage education services for its members. In July of 2017, the Plan agreed to implement an extensive corrective action plan to address and correct the identified deficiencies in the Plan's behavioral health program ("2017 Agreement"). The corrective action plan focused on several areas, including, but not limited to, improved documentation of the Plan's quality improvement efforts for access compliance, improved monitoring of follow-up appointment access and adherence to enrollees' treatment plans uniformly applied across both regions, and improved integration of external contracted provider access data and oversight. The Plan represented to the Department that the corrective action plan and associated deliverables under the 2017 Agreement were completed as of July 18, 2020.

26. The Department's current Enforcement Investigation has confirmed that certain challenges by the Plan related to quality assurance, including monitoring, supervision, and

oversight of the Medical Groups continue to persist. These challenges have contributed to several of the issues addressed in this Settlement Agreement including maintenance of adequate provider networks and effective and functional quality assurance programs. While the Plan has worked to address these issues, despite multiple enforcement actions, and comprehensive corrective action plans, the Plan's shortfalls have continued and have impacted the Plan's ability to ensure adequate and timely access to behavioral health services to its enrollees.

2022 NON-ROUTINE SURVEY AND ENFORCEMENT INVESTIGATION OF THE PLAN'S BEHAVIORAL HEALTH SERVICES

27. Acknowledging that the Plan was managing unprecedented statewide need for behavioral health services exacerbated by the impacts of the pandemic, on May 16, 2022, the Department issued notice to the Plan that the Department would commence a non-routine survey ("2022 Non-Routine Survey") in part, based on complaints received from enrollees, providers, and other stakeholders concerning the Plan's behavioral health operations. The 2022 Non-Routine Survey examined the Plan's Northern and Southern California behavioral health operations including, but not limited to, the Plan's internal and external contracted provider networks, timely access to care, processes for intake and follow-up appointments, appointment scheduling processes, levels of care and associated decision-making processes, medical record documentation and retention practices, and monitoring of urgent appointments. The Department conducted the onsite and virtual portions of the 2022 Non-Routine Survey on November 7-9, 2022, and November 14-15, 2022.

28. On August 15, 2022, approximately 2,000 licensed non-physician behavioral health clinician members of the National Union of Health Care Workers ("NUHW") began a labor strike in the Plan's Northern California region (the "NUHW Strike"). The strike which took place at a time of increased statewide need for behavioral health care, exacerbated the Plan's challenges in connection with the provision of behavioral health care services. On August 12, 2022, the Department initiated the Enforcement Investigation in advance of the NUHW Strike.

As part of the Enforcement Investigation, the Department conducted virtual interviews with Plan and Medical Group personnel on September 13-15, 2022. Additionally, the Department's Office of Enforcement engaged in document discovery and review of Plan documents and enrollee medical records. Given the scope of the strike and the heightened demand in the State, the Plan expected certain difficulties in meeting its enrollees' behavioral health care needs during the strike.

29. In summary, while the Plan was managing unprecedented statewide need for behavioral health services exacerbated by the pandemic and the NUHW strike, the Department's investigation identified deficiencies in the Plan's provision of behavioral health care services, many of which have been ongoing. As explained in more detail herein, the Department identified several areas of concern related to the Plan's provision of behavioral health care in Quality Assurance, Delegate and Provider Oversight, Timely Access, Network Adequacy, Grievance and Appeals, Mental Health Parity, and Communications, among others. The Department identified these areas of concern through document and medical records review and a combination of onsite and virtual interviews with Plan and Medical Group staff.

IDENTIFIED AREAS OF CONCERN WITH THE PLAN'S BEHAVIORAL HEALTH CARE SYSTEM

Area No 1: Oversight

(i) Quality Assurance and Delegation Oversight

30. Health care service plans are required to have procedures in place for continuous review of the quality of care, performance of medical personnel, utilization of services and facilities, and costs. (Health & Saf. Code, § 1370.) To meet the Department's requirements for a QA program, the program must, in part, continuously review the quality of care provided to ensure that the level of care meets professionally recognized standards of practice, quality of care problems are identified and corrected, and appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason. (Cal. Code Regs., tit. 28, § 1300.70, subd. (b)(1)(A)-(E).) The obligation of the

Plan to comply with the Knox Keene Act, cannot be waived, even if the Plan delegates any services to its Medical Groups. (Health & Saf. Code, § 1367, subd. (j).)

31. Despite several past agreements and corrective actions, including the 2017 Agreement, the Plan has been unable to consistently maintain compliance with Quality Assurance requirements. Specifically, the Plan acknowledges that it is accountable for quality oversight and is required to establish a Quality Assurance Program that continuously reviews and monitors quality of care, performance of medical personnel, utilization of services and facilities, and costs, and that ensures a network that is adequate to timely and appropriately meet enrollees' behavioral health needs. As evidenced in repeated survey findings since 2006 and past enforcement actions, the Plan has not put adequate procedures in place to continuously review and maintain compliance with these requirements.

(ii) <u>Oversight of Medical Groups and Providers</u>

32. The Department's investigation, including in connection with the NUHW Strike, confirms that the Plan lacks sufficient access to Medical Group data to ensure transparency and meet its continuous oversight of critical program functions. Specifically, in reference to behavioral health services, the Plan does not have an adequate system for monitoring and evaluating the care provided by the Medical Groups and external contracted providers (in-network providers that are contracted with the Medical Groups and are not directly employed by the Plan or the Medical Groups). Despite requirements that the Plan oversee quality of care, provider performance, and network adequacy, the Plan lacks systems and processes for adequate monitoring of the behavioral health policies and practices implemented by the Medical Groups and external contracted providers. The Plan's responsibility is more than passive monitoring; the Plan has an affirmative, continuous obligation to oversee the quality of its providers and provider network.

33. While the Plan has some processes and procedures in place to review and audit the Medical Groups and external contracted providers, these processes and procedures are not meeting the expected level of continuous oversight (which requires, among

other things, sufficient access to performance data as well as procedures to intervene if necessary) to ensure level of care appropriateness, including treatment plan consistency and appropriateness, and if care is being provided in a timely manner consistent with professionally recognized standards. (Cal. Code Regs., tit. 28, § 1300.70, subd. (b)(1)(A)-(E).) In part, the Plan's failure to meet its oversight obligations is exacerbated by limited access to necessary Medical Group data. The Enforcement Investigation's review of enrollee medical records observed a lack of documentation in enrollee charts and treatment plans. The Plan acknowledges its difficulties in implementing effective oversight of the Medical Groups' activities.

34. The Plan also lacks sufficient oversight of the external behavioral health contracted providers. As noted above, while the external contracted providers are contracted through the Medical Groups, the Plan has a continuing obligation to oversee these providers. However, the Plan does not have effective processes in place, including for Plan intervention, to ensure that enrollees referred to external contracted providers receive timely access to initial and follow-up care, or that the treatment provided by external contracted providers is compliant. (See Area No. 3(i) (External Contracted Provider Network), pp. 18-20.)

(iii) <u>Oversight of Level of Care Appropriateness</u>

35. All medical necessity determinations by a health care service plan concerning behavioral health services, including service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with Health and Safety Code section 1374.721. (Health & Saf. Code, § 1374.72, subd. (a)(7).) Utilization review of all covered behavioral health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. (Health & Saf. Code, § 1374.721, subd. (b).) When conducting utilization review involving level of care placement decisions or

any other patient care decisions that are within the scope of the nonprofit professional association criteria and guidelines, a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria. (Health & Saf. Code, § 1374.721, subd. (c).) A plan may apply other utilization review criteria or guidelines if the health care service is either outside the scope of the nonprofit professional association criteria and guidelines, or relates to advancements in technology or types of care that are not covered in the most recent versions of the nonprofit professional association criteria and guidelines; however, a plan must still base the criteria on current generally accepted standards of mental health and substance use disorder care. (Health & Saf. Code, §§ 1374.721, subd. (c)(1)-(2); 1374.721, subd. (a).) These requirements apply to health plans and any entity or contracting provider that performs utilization review or utilization management functions on behalf of the health plan. (Health & Saf. Code, § 1374.721, subd. (h).)

36. To ensure proper use of the required criteria by the health plan, and any entity or contracting provider that performs utilization review or utilization management functions on its behalf, a health plan shall, inter alia, track, identify, and analyze how the criteria are used to certify care, deny care, and support the appeals process, conduct interrater reliability (IRR) testing to ensure consistency in utilization review decisions, and run IRR reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities. (Health & Saf. Code, § 1374.721, subd. (e)(1)-(7).)

37. During the Enforcement Investigation, the Plan represented that it and the Medical Groups, as required by Senate Bill 855, use criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty – specifically, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII), Early Childhood Service Intensity Instrument (ECSII), World Professional Association for Transgender Health (WPATH), National Standards Project-2

(NSP-2), and American Society of Addiction Medicine (ASAM) guidelines – when making clinical determinations in relation to treatment of mental health and substance use disorders, as required by Health and Safety Code section 1374.721. However, the Department's review of 100 behavioral health medical records indicated that none of the medical records documented scores or criteria from the nonprofit professional associations, including LOCUS, CALOCUS, or ASAM. Additionally, the Plan did not provide clinical criteria documentation that would reflect implementation or use of the appropriate clinical criteria. The Department only found the Plan's use of the required clinical criteria in grievance files – analysis which was conducted via email – not copied to or documented in the enrollee's medical record.

38. Instead, the enrollee medical records reviewed by the Department indicate that Medical Group providers are presented with an enrollee's self-assessment BHI score through the Tridiuum platform. The enrollee medical records also include self-assessment scores from an Adult Outcome Questionnaire (AOQ) and Personal Health Questionnaire (PHQ). Further, the enrollee medical records include scores related to General Anxiety Disorder (GAD) and Alcohol Use Disorder (AUD).

39. While these scores are intended to measure an enrollee's treatment progress and assist in directing care going forward, the application of these scores is inconsistent across the board. Enrollee medical record review indicates that higher acuity scores do not consistently result in higher acuity placement or treatment frequency. Additionally, although the Plan conducts treatment plan audits, the Plan did not provide documentation reflecting that review of the substance of treatment plans was performed to determine the treatment plans' appropriateness for the enrollees' conditions or whether appropriate clinical criteria were utilized in developing the treatment plans. This lack of submitted documentation regarding substantive review of treatment plans further indicates the Plan lacks sufficient oversight of the Medical Groups.

40. Furthermore, the Plan has asserted that it conducts IRR testing to evaluate consistency with providers' application of utilization review criteria. However, the

Plan's IRR policy submitted with the Department in Filing no. 20211027-8 only applies to medical/surgical services. The Plan has not filed an IRR policy that applies to behavioral health services, nor did audit documentation address how IRR review of behavioral health services was to be conducted.

41. Of additional concern, Medical Group clinicians statewide consistently use Microsoft Teams chats and groups to make clinical decisions and determinations on level of care and treatment planning. The Plan's data retention policy for Microsoft Teams chat records states that generally records are deleted after 90 days, though this is subject to exceptions based on various document hold and preservation requirements. These clinical and treatment planning discussions are not consistently copied to the enrollees' medical records. As such, the Plan is not ensuring that the Medical Groups effectively document clinical reviews and determinations, and the Plan is unable to review the decisions for audit purposes necessary to carry out its oversight functions.

Area No. 2: Access

(i) Timely Access and Network Adequacy

42. Health care service plans must ensure that their networks have adequate capacity and availability of licensed providers to offer enrollees appointments for covered services that meet specific timeframes. (Health & Saf. Code, § 1367.03, subd. (a)(5); Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c).) The obligation of a health plan to comply with the timely access requirements under Section 1367.03 shall not be waived if the health plan delegates to its provider groups or other contracting entities any services or activities that the health plan is required to perform. (Health & Saf. Code, § 1367.03, subd. (c).)

43. The Plan acknowledges that it lacks sufficient behavioral health providers in its Medical Groups and external contracted provider networks. In an effort to address the deficiencies identified herein, the Plan represented to the Department that it has made significant strides and improvements in expanding its behavioral health network. Nevertheless, this is an area that requires significant review and continued improvement. While the Plan has

the ultimate responsibility to ensure network adequacy to provide timely and appropriate behavioral health care services, the Department has observed that the Plan relies in part on the Medical Groups to monitor the Plan's network for sufficient capacity, and has delegated to the Medical Groups the responsibility for contracting with external providers. However, the Plan has not been performing adequate oversight of the process to ensure that the Medical Groups are adequately performing this task. Specifically, the Plan has not continuously reviewed necessary data nor intervened to ensure that the Plan has an adequate network. If the Medical Groups are not performing their obligation to the Plan to ensure that behavioral health care services are reasonably available to Plan enrollees, then the Plan must intervene and take appropriate steps to address this issue. The requirement to maintain adequate networks and ensure timely access is not waivable and rests with the Plan. This lack of clinical staff has resulted in excessive wait times for enrollee individual therapy appointments, and has potentially contributed to a heavy reliance on group therapy, as discussed in paragraph 50 below.

(ii) Initiation of Care and Tracking First Appointments

44. When seeking behavioral health care, the Enforcement Investigation documented that the enrollee experience can be unnecessarily complicated and vary significantly based on Plan or Medical Group interaction. Enrollees are provided with several different phone numbers and methods of contact for appointments or to initiate care, and the level of service an enrollee receives is inconsistent depending on which point of contact is used.

45. Plan enrollees have complained that they face significant delays and obstacles when seeking behavioral health therapy. These delays and obstacles are due, in part, to the structure of the Plan's behavioral health care intake process, specifically related to its Connect 2 Care program in the Northern California region. For new requests for behavioral health care, enrollees are generally directed through Connect 2 Care after an enrollee has been screened and tracked through the eConsult process that requires a brief clinical review or

triage of the enrollee's concerns. The Department recognizes that Connect 2 Care program was a well-intentioned and innovative program developed by the Plan's Northern California region in collaboration with NUHW, as well as in consult with the Department in connection with the 2017 Agreement. However, the Plan acknowledges certain challenges with respect to the program require its reevaluation by the Plan.

46. Connect 2 Care appointments are generally conducted remotely and the Connect 2 Care clinicians do not become the enrollees' regular treating clinicians, which often results in the enrollees having to explain their behavioral health concerns multiple times to other clinicians. Additionally, the Plan's Northern California region generally performs all intake appointments with only Medical Group providers, prohibiting enrollees from having intake appointments with external contracted providers regardless of excessive appointment wait times.

47. Even though the Connect 2 Care clinicians perform an assessment of enrollees and are not the enrollees' treating providers (though in some instances they provide initial care and/or interventions) the Plan has consistently tracked Connect 2 Care intake assessments as appointments for services to satisfy the timely access requirements under Health and Safety Code section 1367.03, subdivision (a)(5)(E) and (F), under the rationale that the Plan believes that the intake process of evaluating a patient and determining the proper treatment plan for the patient is a part of providing appropriate care. However, the Plan cannot confirm that every appointment with a Connect 2 Care clinician results in a treatment plan appropriate for the enrollee's condition, although as mentioned above the Plan conducts treatment plan audits. Further, the Plan does not track the elapsed time between an enrollee's initial request for a behavioral health appointment and the earliest date offered for the appointment for services with a treating provider.

(iii) Follow-up Appointments and Wait Times

48. Beginning July 1, 2022, a health plan must ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to

offer non-urgent appointments with nonphysician behavioral health providers within 10 business days of the prior appointment for enrollees in an ongoing course of treatment for an ongoing mental health or substance use disorder condition. (Health & Saf. Code, § 1367.03, subd. (a)(5)(F).) The wait time for an appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, has determined and noted in the medical record that a longer wait time will not have a detrimental impact on the health of the enrollee. (Health & Saf. Code, § 1367.03, subd. (a)(5)(H).)

49. At the Department's request, the Plan provided analysis of appointment wait times, which demonstrated that average wait times for non-urgent follow-up behavioral health appointments were longer than prescribed by law. These delays are in part due to the structure of the Plan's behavioral health care processes. The Plan's own analysis determined that in 2021, average non-urgent follow-up appointments for behavioral health therapy were completed within 19 business days of the prior appointment (average across the entire state). In 2022, only 44% of behavioral health therapy non-urgent follow-up individual appointments with internal providers were completed within 10 business days of the prior appointment, whereas 93% of group appointments were completed within 10 business days of a prior appointment. In 2022, average non-urgent follow-up individual appointments for behavioral health therapy were completed within 18.1 business days of the prior appointment. From July 1, 2022, when Health and Safety Code section 1367.03, subdivision (a)(5)(F) went into effect, through December 31, 2022, average non-urgent follow-up individual appointments for behavioral health therapy were completed within 21.4 business days of the prior appointment (average across the entire state). During the same time period the average non-urgent follow-up appointment completion time for group therapy was 5 business days from the prior appointment, and from July 1, 2022, through December 31, 2022, the average completion time was 5.9 business days from the prior appointment.

50. The Department's review of enrollee medical records indicated a heavy

reliance on outpatient group programs and classes to treat enrollees' behavioral health conditions as opposed to individual therapy or higher levels of care. While outpatient group therapy can be an effective mode of therapy when clinically appropriate, the Department's review of 100 enrollee medical records identified that outpatient group programs and classes were recommended or considered in 70 of the files reviewed. Enrollees have expressed discomfort with receiving treatment primarily in a group setting, and the Enforcement Investigation's review of enrollee medical records indicated that many enrollees chose not to engage in group therapy settings but were not offered alternative treatments or more frequent individual therapy. Further, the majority of the files did not state why an enrollee was referred to a specific group, or whether the recommended group, received in conjunction with any other therapeutic modality, represented a specific level of care consistent with the non-profit criteria guidelines. Moreover, the use of groups and classes potentially obscures the wait times for follow-up appointments if the recommended groups and classes do not actually offer the medically necessary treatment and level of care that are appropriate for each enrollee's mental health or substance use disorder.

51. In response to the follow-up appointment standards in Senate Bill 221, effective July 1, 2022, the Plan, through its Medical Groups, implemented policies and procedures, including standardized templates, for providers to use when documenting enrollees' behavioral health appointments to help track follow-up appointments. However, during the period that data was reviewed the Medical Groups had not enforced consistent use of these templates, nor had the Medical Groups required all behavioral health providers to use these templates. In addition, the templates could be altered at the discretion of individual behavioral health providers.

<u>Area No. 3: Network and Referrals</u>

(i) <u>External Contracted Provider Network</u>

52. As discussed above, the Plan is required to continuously oversee and monitor the external contracted providers to the same extent as the Medical Group providers.

The Plan has not adequately done so and has to a significant extent, instead, relied on the Medical Groups. While the Plan has expanded and improved access to its external contracted network, during the time period covered by the Department's Enforcement Investigation, the Department observed that the Plan's lack of oversight and management of its network has resulted in significant issues relating to initial and follow-up appointments with the Medical Groups' processes of referring enrollees to external contracted providers.

53. At the Department's request, the Plan provided data analysis for wait times for follow-up, non-urgent individual behavioral health therapy appointments with external contracted providers. As mentioned above, the Plan's data analysis considered the times between completed appointments, not offered appointments. The Plan's analysis demonstrated that wait times for external contracted providers were better than for appointments with Medical Group providers. According to the Plan, 83% of non-urgent individual behavioral health therapy follow-up appointments with external contracted providers were completed within 10 business days of the prior appointment. The Plan's analysis shows that, in 2022, the average non-urgent individual behavioral health therapy follow-up appointment was completed within 8.2 business days of the prior appointment, and from July 1, 2022, through December 31, 2022, was completed within 8.6 business days of the prior appointment (average across the entire state).

54. A Clinical Care Pathways document allows Initial Assessment Coordinators (IAC) the option to refer enrollees with moderate (PHQ/GAD scores up to 14) or moderately severe acuity levels (PHQ/GAD scores of 15-19) to external contracted providers through Connect 2 Care. However, the same document does not allow IACs the option to refer enrollees with severe (PHQ/GAD scores above 20) acuity levels to refer directly to external contracted providers through Connect 2 Care. The Plan asserts that PHQ/GAD scores are not dispositive with respect to referrals or treatment.

55. The Plan does not directly arrange for enrollee appointments with external contracted providers. Rather, in general, except for external contracted providers who use

Tridiuum (below), the external contracted provider contacts the enrollee or, in some cases, the enrollee is required to contact the provider from a list of providers. Further, the Plan, in general, does not have immediate access to data to track whether referrals to all external contracted providers result in appointments and, if so, whether those appointments are timely. While some external contracted providers provide immediate booking data for initial appointments, not all do, and there is currently no Plan requirement that they do.

External Contracted Providers that Use Tridiuum

56. For some external contracted providers, initial appointments are scheduled through the Tridiuum system and documented in the KP HealthConnect medical record, which is the centralized medical record system used by the Plan However, external contracted providers are not required to document clinical or progress notes in the KP HealthConnect medical record. Record of ongoing patient encounters may be documented through Tridiuum if the external contracted provider performs a progress evaluation through the program. However, if no progress evaluation is performed for an appointment, no documentation of the appointment would immediately appear in the KP HealthConnect medical record.

External Providers referred through Tapestry

57. For enrollees referred to external contracted providers that do not use Tridiuum, a referral letter is generated through Tapestry. The letter sent to the enrollee includes the name of the external provider network and the contact information for scheduling an appointment. The enrollee, or the external contracted provider, must then schedule an appointment. The Plan does not generally have direct access to the external contracted providers' scheduling systems, although there may be exceptions for specific external contracted providers. As such, a specific provider may show as having appointment availability when the referral is made, but the information the Plan is basing this determination on may be outdated.

(ii) Adequacy of Higher Acuity Treatment Facilities

58. During the Enforcement Investigation, the Department requested data on the contracted Partial Hospitalization Program (PHP) and Residential Treatment Programs (RTC). The Plan provided a list of 78 contracted PHP facilities and 144 contracted RTC facilities. Twelve of the reported PHP facilities were Plan Hospitals. The Plan randomly contacted a sample of the non-Plan contracted facilities to determine the soonest available admission date. Of the 53 RTC facilities sampled, only 29 had availability within a week. Of the 37 PHP contracted facilities sampled, 12 responded that they were not a PHP program; 7 of the facilities had a waitlist of longer than two weeks; 3 of the facilities were closed temporarily or permanently; and 1 was no longer contracted. Only 14 of the sampled PHP facilities had immediate availability or an opening within two weeks for PHP services. The Plan's shortage of contracted PHP and RTC facilities with current availability indicates the Plan has an inadequate network of facilities that are able to treat enrollees with higher acuity levels in an appropriate treatment milieu. While the Department is aware of a general shortage of PHP and RTC providers in the state, the Plan can do more to expand its network.

(iii) Referrals to Out of Network Providers

59. A health care service plan shall arrange for the provision of covered services from providers outside the plan's network if not available in network where medically necessary for the enrollee's condition. (Health & Saf. Code, § 1367.03, subd. (a)(7)(C).) For medically necessary behavioral health services not available in network within the geographic region, or within timely access standards, the plan shall arrange for coverage of such services outside the plan's network in accordance with Health and Safety Code section 1374.72, subdivision (d). (*Ibid.*)

60. The Plan has not consistently arranged for out-of-network care when the Plan cannot offer a member a timely appointment. The Plan relies on the Medical Groups to make out-of-network referrals, and the Plan has not exercised sufficient performance monitoring or continuous oversight to ensure appropriate access to out-of-network providers.

The Enforcement Investigation included a review of grievance files wherein an enrollee was requesting referral or coverage for out of network care because the Plan could not offer a timely in-network appointment and, the Plan, with few exceptions, would refer the enrollee to its external contracted providers.

Area No. 4: Grievance and Appeals

61. Health care service plans must have a grievance system established in writing and approved by the Department which provides reasonable procedures that shall ensure adequate consideration of enrollee grievances and rectification where appropriate. (Health & Saf. Code, § 1368, subd. (a)(1).) The health plan's grievance process shall provide for written acknowledgement within five calendar days of receipt of a grievance unless an exception applies. (Health & Saf. Code, § 1368, subd. (a)(4)(A).) The grievance system shall require the health plan to resolve standard grievances within 30 days. (Health & Saf Code, § 1368.01, subd. (a).) A grievance regarding a delay or difficulty in obtaining an appointment for covered services may constitute an initial request for an appointment. (Cal. Code Regs, tit. 28, § 1300.67.2.2, subd. (b)(2).)

62. During the Enforcement Investigation, interviews conducted with Plan and Medical Group staff demonstrated that, in an effort to address the difficulty in locating timely behavioral health appointments, the Plan implemented a practice of routing appointment requests through its grievance and appeals process. This can result in enrollees receiving offered appointments and referrals to external providers outside of the timely access timelines, given that by the time the grievance is resolved, the timeframe to receive a timely appointment may have passed. The Enforcement Investigation's review of grievance files related to behavioral health care appointments noted that in 118 files reviewed, 28 resulted in referrals to external providers. Of the 28 external provider referrals, 22 of the referrals did not provide a specific appointment date, but instead stated that a referral had been initiated and the enrollee would receive the referral in 7-10 days.

63. The Plan provided the Department with grievance and appeals data for

the period of August 8, 2022, through October 21, 2022, relating to behavioral health services in the Plan's Northern California region. The Department noted that during that timeframe, the Plan opened 29,906 grievances and 18,779[2] of those grievances were subject to the 30-day grievance resolution requirement. However, 5,878[3] grievances, or 31.3%, of the 18,779 grievances were not resolved and closed within the required 30 days.

64. The Department noted 27,863[4] grievances that were subject to the requirement to issue a written acknowledgment of the grievance within 5 calendar days, the Plan failed to acknowledge receipt of 5,052[5] grievances out of the 27,863 submitted. The Plan's routing of appointment requests through its grievance and appeals process during the NUHW Strike also resulted in delayed grievance acknowledgments and responses through the Plan's already overwhelmed grievance and appeals system. Additionally, the Plan's practice of referring enrollees to external providers, which requires a referral letter to be issued, resulted in multiple grievances that were not adequately resolved in 30 days.

Area No. 5: Cancelled Appointments During the NUHW Strike

65. The law requires that when it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice. (Health & Saf. Code, § 1367.03, subd, (a)(3); Cal. Code Regs., tit. 28. 1300.67.2.2, subd. (c)(3).)

66. As noted above, the NUHW Strike created an unusually difficult

---

[2] 18,779 represents the total number of grievances received by the Plan at least 30 days prior to the end of the reporting period on October 21, 2022.

[3] 5,878 represents the total number of grievances that were resolved or in "pending" status beyond 30 days of the receipt date, excluding grievances that were resolved on the next business day following a weekend or holiday, and grievances that were withdrawn before the expiration of the 30-day response period.

[4] 27,863 represents the total number of grievances received by the Plan at least 5 days prior to the end of the reporting period on October 21, 2022.

[5] 5,052 represents the total number of grievances where an acknowledgement letter was not sent to the enrollee within the required 5 days, excluding grievances that were resolved or withdrawn within the 5-day timeframe.

circumstance for the Plan and the Medical Groups to manage. While the Plan faced significant challenges related to the NUHW Strike, the Plan was obligated to comply with timely access requirements during the NUHW Strike period. During the NUHW Strike in Northern California, the Plan reported that 111,803 behavioral health appointments (individual and group) were cancelled, affecting a total of 63,808 enrollees. Of these appointments, 69,080 behavioral health appointments (individual and group) were cancelled by the Medical Group, affecting a total of 46,631 enrollees. Of the Medical Group-initiated cancelled appointments, there were 29,645 enrollees for whom the cancelled appointment was not rescheduled internally, or for whom the cancelled appointment was rescheduled internally outside of 10 business days. However, the Enforcement Investigation revealed multiple appointments – either cancelled, rescheduled, or bridge appointments – that were not reflected in the Plan's appointment documentation, casting doubt on the accuracy of the Plan's calculations and appointment tracking system.

67. During the NUHW Strike, the only means available to the Plan to fully determine whether an offered appointment was medically appropriate was a chart audit of each member's records conducted by the Plan's Appointment Audit Team. The Plan provided a Rescheduling Review Job Aid to the Audit Team that instructed the reviewer to notate whether a treatment plan and clinically appropriate appointment wait time was documented in the enrollee's medical record. The Auditors were then instructed to confirm if the enrollee's provider had documented that appointments rescheduled outside of the recommended wait time would not be detrimental to the enrollee. However, they were not instructed to review if the appointment cancellation or rescheduling was consistent with good professional practices based on the provider's most recent assessment of the enrollee or the enrollee's most recent health care needs. If a cancelled appointment was not rescheduled, was rescheduled outside of 10 business days (but did not reflect non-detriment documentation), or reflected risk criteria, the Plan's Audit Team would refer the appointment to the Medical Group's Audit Team for further review and potential rescheduling. In addition to the Medical Group Audit Team's

review, the Medical Group would also apply its usual workflow to flag and reschedule appointments that needed rescheduling.

68. The Department noted in its Enforcement Investigation that the Plan's appointment cancellation audit criteria training was inconsistent. The Plan provided its Behavioral Health Chart Review Teaching Guide, which does not include a publish date, and instructs reviewers that behavioral health groups or classes do not count as an appointment for tracking and audit purposes. However, the Plan's New, Group, Class Appointment Audit guide, dated September 24, 2022, instructs reviewers that groups and classes do count as appointments for audit purposes. Finally, a Plan document, titled IRR Review Chart, dated September 19, 2022, instructs reviewers not to count groups or classes as appointments for tracking and audit purposes. The Plan's inconsistent guidance on the treatment of classes and groups given to the Audit Team further calls into question the accuracy of the Audit Team's results and data concerning the thousands of cancelled appointments during the NUHW Strike.

Area No. 6: Mental Health Parity

69. Health care service plans shall provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. (Health & Saf. Code, § 1374.72, subd. (a)(1).)

70. Enrollees who seek behavioral health services face greater obstacles and challenges accessing behavioral health care and, even after obtaining it, retaining such care. As discussed above, in order to access a behavioral health provider, Plan enrollees in the Northern California services area often have to explain their behavioral health concerns multiple times to different clinicians. In contrast, an enrollee generally is not required to undergo multiple screenings before accessing certain other routine medical care. The Plan represented that certain medical centers, primarily in the Plan's Southern California service area, have in place limitations on referrals, and enrollees are often unaware of the limitations. In some instances, referrals to external contracted providers were limited to instances where a Medical Group provider was unavailable. Additionally, the Plan represented that in certain

medical centers, enrollees generally could not schedule multiple behavioral health appointments at one time, despite being provided a treatment plan requiring specific appointment frequency. For example, the Plan asserted that in some medical centers, enrollees were generally limited to scheduling one behavioral health appointment at a time while enrollees under other medical treatment plans do not face the same restriction.

Area No. 7: Communications and Advertising

71. Health care service plans may not use or permit the use of any advertising or solicitation that is untrue or misleading. (Health & Saf. Code, § 1360, subd. (a).) A written or printed statement or item of information is misleading whether or not literally true, if in total the statement or item may be understood by a person not possessing special knowledge regarding health care coverage, indicates any benefit or advantage or absence of any exclusion limitation or disadvantage. (Health & Saf. Code, § 1360, subd. (a)(2). Moreover, California's Business and Professions Codes (e.g., Sections 17200, et seq.) prohibit inaccurate advertising and communications.

72. The Plan has had a consistent and ongoing issue with communications with enrollees regarding access to behavioral health services. The Plan reported that enrollees have complained that they have difficulty understanding how to access behavioral health care, including how to obtain referrals to external contracted providers. While enrollees do not require a PCP referral to access initial behavioral health services, enrollees cannot typically self-refer to external contracted providers for behavioral health services; however, when enrollees do self-refer to external contracted providers, it is the Plan's policy to reimburse for such treatment. However, certain Plan-issued communications could lead enrollees to believe they can self-refer to external contracted providers.

73. By way of example, the Plan's Evidence of Coverage ("EOC") defines a "Plan Provider" as "A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider." The EOC defines a "Non-Plan Provider" as "A provider other than a Plan Provider." These definitions

may cause confusion to enrollees when determining if external contracted providers are considered Plan Providers or Non-Plan Providers. Furthermore, the Plan's use of the term "External (Out-of-Plan) Referrals" (which refers to out-of-network providers) in its Utilization Management document may create further confusion to enrollees with no specialized knowledge regarding health care coverage. As each type of provider classification carries different referral or prior-authorization requirements, the unclear use of each term may result in enrollees misunderstanding the benefits under the Plan.

74. The Department identified individual clinical records where requests were submitted by enrollees and Medical Group Providers for referrals to external contracted providers and out-of-network providers. The documents indicated that a referral to external contracted providers required approval by the Medical Group, although the Medical Group does not make coverage decisions for the Plan. This process may be confusing to enrollees with no specialized knowledge regarding health care coverage when compared against the language pertaining to referrals to Non-Medical Group providers contained in the Plan-issued EOC.

ACKNOWLEDGEMENTS

75. Overall, the Department has noted that the Plan's processes, systems, and level of oversight must improve. The Plan has not consistently performed continuous review and appropriate oversight, including intervening where needed, of quality assurance, delegated functions, timely access, network adequacy, and grievance and appeals, among other things, related to behavioral health services.

76. While, as described above, the Department has identified deficiencies, the Plan has represented that, in recent years and since the Department's investigation began, the Plan has invested significant sums in improving its behavioral health programs and access including the following: (i) since 2020, the Plan's annual cost to provide mental health treatment to members has increased by $1.1 Billion; (ii) since the start of the Non-Routine Survey, KP has increased its spending by $450 million on outpatient treatment, intensive

outpatient treatment (which includes residential treatment for addiction medicine) and autism; and (iii) since 2020 the Plan invested $195 million in new built clinic facilities for 329 new mental health provider offices.

77. After engaging in discussions with the Department, the Plan accepts the above discussed areas of concern and has expressed willingness to undertake a systemic overhaul and transformational change of the Plan's behavioral health delivery system to improve the Plan's enrollees' experiences and treatment outcomes. In addition to the above areas of concern identified by the Department, the Plan further acknowledges areas needing improvement with respect to the Plan's internal and external contracted provider networks, timely access to care, processes for intake and follow-up appointments, appointment scheduling processes, levels of care and associated decision-making processes, medical record documentation and retention practices, monitoring of urgent appointments, and communications with members.

78. The Plan agrees that it is in the best interest of the Plan's enrollees for the Plan to enter into this Settlement Agreement and resolve the Enforcement Investigation and 2022 Non-Routine Survey. The Department also acknowledges the Plan's and Medical Groups' commitment to care of Plan enrollees and patients.

79. The Plan agrees to be bound by all settlement terms and obligations as set forth in this Settlement Agreement, including the imposition of a corrective action plan, and acknowledges that failure to comply with the corrective action plan will subject the Plan to disciplinary action under Health and Safety Code section 1386, subdivision (b)(19). Failure to comply with the terms of the agreed-upon corrective action plan and/or settlement terms and obligations may subject the Plan to additional administrative penalties, and any other remedies available to the Director.

80. During the term of this Settlement Agreement, including during the Consultation Period (as set forth in paragraph 107 below), the Department's Office of Enforcement may become aware of new facts arising after the execution of this Settlement

Agreement which are related to the subject matter of the Corrective Action Areas and which the Department may want the Plan to investigate and/or address. Should that happen, the Office of Enforcement may request to meet and confer with the Plan to determine if the issues can be, or are being, addressed through the Corrective Action Work Plan. Subject to the provisions of this Settlement Agreement and the release of claims herein, the Department may utilize any means necessary to ensure the Plan's compliance with the Knox Keene Act and regulations.

81. At the conclusion of the 2022 Non-Routine Survey, the Department will issue a final report as required by Health and Safety Code section 1380, subdivision (h)(2), that identifies deficiencies that have been corrected by the Plan and describes remedial actions for deficiencies for which correction is or will be in progress. By entering into this Settlement Agreement, the Plan is not waiving any rights it has under the law, including the Knox-Keene Act, with respect to the report.

82. The Plan agrees that any deficiencies identified in the 2022 Non-Routine Survey Final Report that are not addressed in the Corrective Action Work Plan developed under paragraph 105, shall be addressed by the Plan through a modified Corrective Action Work Plan subject to the Department's approval.

83. The Plan agrees that the Department shall conduct a Follow-up Survey to the 2022 Non-Routine Survey Final Report as required by Health and Safety Code section 1380, subdivision (i)(2). Any uncorrected deficiencies identified in the 2022 Non-Routine Survey Follow-up Report that are not encompassed by the terms of this Settlement Agreement, and any penalty amounts paid by the Plan under this Settlement Agreement are exclusive of any future penalties the Department may determine are warranted by the 2022 Non-Routine Survey Follow-up Report.

MONETARY PENALTY

84. The Plan agrees to pay an administrative penalty in the amount of $50 Million (Fifty Million dollars) ("Penalty Amount") to resolve the issues identified by the

Enforcement Investigation and 2022 Non-Routine Survey Final Report. The Plan is hereby ordered to pay to the Department $40 Million (Forty Million dollars) of the Penalty Amount within 10 business days of the effective date of this Settlement Agreement.

85. The Department, through its Director, has determined that the remaining $10 Million (Ten Million dollars) of the Penalty Amount shall be paid only if, after the conclusion of the Consultation Period, the Department concludes that the Plan unreasonably failed to meet its obligations under this Settlement Agreement. The payment of this amount would be in addition to any penalties the Director may assess pursuant to Health and Safety Code section 1380, subdivision (i)(2).

INVESTMENT COMMITMENT

86. In addition to the Penalty Amount, the Plan agrees to invest $150 Million (One Hundred and Fifty Million dollars) ("Investment Amount") in the next five years to expand and improve behavioral health for Plan enrollees and for community members throughout California, including developing and implementing new models of care, investing in partnerships and training to expand access to care. The Plan shall have the discretion to determine the specific amounts and projects toward which it will invest the Investment Amount. It is the Department's intention and desire that the Plan's investments include projects designed to develop new models of care that set the standards for behavioral health care in California. The Plan's investment shall include the following projects and programs:

(1) Workforce development programs that transform the landscape for MH service delivery by growing diverse mental health professionals for mental health and substance use disorder care (including Mental Health Scholars Academy and the Behavioral Health Training Institute programs);

(2) Partnerships with local schools and universities and engagement with local charitable organizations/partners for expansion of community mental health training programs;

(3) Programs designed to decrease stigma around seeking mental health/substance use disorder care and reduce youth suicide prevalence;

(4) Prevention and Early Intervention programs for mental health and wellness programs for school aged children and families;

(5) Programs designed to support reductions in depression/anxiety for California's youth through cognitive behavioral therapy informed approaches at middle schools across California to equip students with the knowledge and skills to reduce or prevent symptoms;

(6) Growing community training pathways for peers/para-professionals to provide support for Californians on their mental health and substance use disorder care journey; and

(7) Supporting/investing in community based organizations providing mental health and substance use disorder care for high risk and high acuity community members.

87. In connection with the Quarterly Meetings required under this Settlement Agreement (Paragraph 110 below), the Plan shall provide information to the Department regarding its anticipated investments of any of the Investment Amounts to enable the Department to provide feedback and ensure that it is within the scope of this Settlement Agreement.

RECITALS

88. The acknowledgments made by the Plan herein are only for the purposes of this Settlement Agreement and shall not be admissible in any other criminal or civil proceeding, but may be used by the Department in future administrative proceedings and/or in considering penalties against the Plan.

89. In the event of any future litigation (administrative or civil) between the Department and the Plan, the Plan agrees it will not object on the basis of California Evidence Code section 1151 to the admissibility of corrective actions taken by the Plan under this

Settlement Agreement.

90. Each signatory below warrants and represents that she or he has authority to sign on behalf of, and to legally bind, her or his respective entity.

91. This Settlement Agreement shall be binding on all Parties, including all principals, executors, administrators, representatives, and successors in interest.

92. This Settlement Agreement is the entire agreement between the Parties and supersedes any prior negotiations, representations, or agreements, whether written or oral.

93. This Settlement Agreement may not be altered, amended, or otherwise changed or modified, except in writing signed by both Parties.

94. This Settlement Agreement shall take effect upon execution by both Parties.

95. The Parties understand and agree that facsimile or PDF copies of the hard copy of the original electronically-signed Settlement Agreement shall have the same force and effect as the original. After the Plan representative has executed the document, the Plan shall forward the hard copy of its original electronically-signed Settlement Agreement to the Department of Managed Health Care's Office of Enforcement, located at 980 9th Street, Suite 500, Sacramento, CA 95814. This Settlement Agreement may be executed in counterparts.

AGREEMENT

WHEREFORE, the parties hereby agree and stipulate as follows:

96. **Comply with all laws.** The Plan shall obey all federal, state, and local laws, rules, and regulations governing health care service plans. Nothing in this Settlement Agreement limits the Plan's obligations to comply with the requirements of all applicable state and federal laws and regulations. In the event that the Plan contends that any provision or portion of this Settlement Agreement is inconsistent with or invalid based on (1) legislation enacted or regulations adopted by the State of California or federal government which have not been superseded, or (2) a final judgment has been entered by a court of competent

jurisdiction that is binding precedent from which no appeal or other judicial review has been taken, or, if appealed, the final judgment has been affirmed by the court of last resort and is no longer subject to further appeal or review, the process described below shall be followed.

97. The Plan will give written notice to the Department of its contention that there has been a change in the law and shall indicate that such notice is being provided pursuant to this Paragraph 97 of the Settlement Agreement. Such notice shall be sent to the attention of the Director. The Parties shall meet and confer in good faith, and if the Parties do not reach agreement within sixty (60) days after the Department's receipt of the Plan's written notice referenced above, the Plan may file a declaratory relief action on the question of whether, and to what extent, the alleged change in the law affects the Plan's responsibility to continue to perform in accordance with this Settlement Agreement. Any legal action taken by the Plan shall be venued in accordance with Paragraph 102, and may not be filed by the Plan any sooner than the sixty-first (61st) day after the Department receives the Plan's written notice. The Plan shall continue to perform in strict compliance with this Settlement Agreement (1) while the Parties are engaging in the meet and confer process, and (2) during the pendency of any such legal action and/or proceeding relating to the change in law that allegedly conflicts with the Plan's obligations under the Settlement Agreement, and (3) until a final and enforceable judgment is entered in favor of the Plan (i.e., a final judgment has been entered from which no appeal or other judicial review has been taken, or if appealed, the final judgment has been affirmed by the court of last resort and is no longer subject to further appeal or review). The Department shall retain its full enforcement authority regarding the terms of this Settlement Agreement during the pendency of litigation regarding the Plan's contention that a change in the law relieves it of its responsibility to continue to perform in accordance with this Settlement Agreement.

98. This Settlement Agreement fully and finally resolves the Enforcement Investigation and the 2022 Non-Routine Survey Final Report, and any other administrative or civil action based on or related to the Enforcement Investigation and the 2022 Non-Routine

Survey Final Report, and/or facts and circumstances upon which the Enforcement Investigation and the 2022 Non-Routine Survey Final Report are based on or before the date this Settlement Agreement is executed. The Department agrees to administratively close any open or pending enforcement referrals for which the alleged violations are addressed in the corrective action plan set forth herein. Nothing in this Settlement Agreement shall constitute a disclaimer, accord, relinquishment, estoppel, or a waiver of any form of any right or authority of the Department, including without limitation to continue with its current investigations, surveys, audits, or examinations and/or to exercise its enforcement and disciplinary authority relative to, or independent of, those investigations, audits or examinations, with the exception of those made the subject of the Enforcement Investigation, and the 2022 Non-Routine Survey Final Report. Subject to the foregoing release, nothing in this Settlement Agreement shall limit, affect, or inhibit in any manner the Department's powers to initiate any new or additional investigations, routine or non-routine audits or examinations, or to require and/or order any remediation, penalties, and/or other remedies the Department deems necessary or appropriate to carry out the objectives and purposes of this Settlement Agreement and/or the Knox-Keene Act, including, without limitation, actions necessary to protect and/or effectuate remediation to enrollees and/or providers.

99. **Director's Order.** The Parties agree that the terms of this Settlement Agreement are not only a contract but they are additionally an Order of the Director, and the Department may exercise any and all aspects of its enforcement authority to enforce the Plan's compliance with any and/or all of its obligations under this Settlement Agreement, and that any remedy available to the Director is not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the Director to enforce this Settlement Agreement.

100. Given its role as the regulator of health care service plans in California and with respect to interpretation of the Knox-Keene Act and regulations promulgated thereunder, the Department will monitor and evaluate the Plan's provision of behavioral health

services and the Plan's compliance with its obligations under applicable laws including the Knox-Keene Act, this Settlement Agreement and the Corrective Action Plan required herein. In so doing, the Department will exercise the discretion vested in it by appliable law and rely on its expertise regarding the subject matter of this Settlement Agreement to monitor the Plan and ensure its compliance with all applicable laws and this Settlement Agreement.

101. **Governing Law**. This Settlement Agreement shall be governed by and construed in accordance with the laws of the State of California without regard to conflicts of law principles.

102. **Venue**. Each Party irrevocably submits to the jurisdiction of the California Office of Administrative Hearings located in Sacramento, California, or the California Superior Court located in Sacramento County, California, over any suit, action, or other proceeding arising out of or relating to this Settlement Agreement, and irrevocably agrees that all claims with respect to any such suit, action, or proceeding may be heard and determined in such venue.

103. **Severability.** In the event any term or portions of any term set forth herein shall be declared invalid or unenforceable for any reason by a court of competent jurisdiction, such term or any portion of any term, to the extent declared invalid or unenforceable, shall not affect the validity or enforceability of any other terms, and such other terms shall remain in full force and effect and shall be enforceable to the maximum extent permitted by applicable law.

CORRECTIVE ACTION PLAN

104. **Retention of Consulting Team.** The Plan shall retain a consulting team ("Consulting Team") pursuant to the Consultation Agreement discussed in Paragraph 106. The Plan will bear all costs of the Consulting Team's services throughout the Consultation Period.

105. **Purpose of the Consulting Team.** The Plan will work with the Consulting Team to develop a work plan (the "Corrective Action Work Plan") to address the Corrective Action Areas. The Corrective Action Work Plan will set forth corrective actions, performance measures, reporting provisions, timelines, deadlines, deliverables, benchmarks, and expected

outcomes. The Consulting Team will also aid the Plan with respect to implementing the Corrective Action Work Plan and with respect to reporting to the Department regarding the Plan's progress.

106. **Consultation Agreement.** Prior to the execution of the Settlement Agreement, the Plan and the Consulting Team will execute an agreement setting forth the scope of the Consulting Team's services ("Consultation Agreement") related to this Settlement Agreement. In the event of conflict between the Settlement Agreement and the Consultation Agreement, the Settlement Agreement controls.

107. **Consultation Period.** Except as modified pursuant to Paragraph 108 below, the Consultation Period shall be two years from the date this Settlement Agreement is finalized (the "Consultation Period").

108. **Extension of the Consultation Period.** The Consultation Period may be extended at the Plan's discretion; however, the Department shall make the final determination as to whether the Plan's decision complies with the terms of the Corrective Action Plan.

109. **Quarterly Reports.** The Consulting Team shall provide the Department with status updates and progress review reports of the activities performed and outcomes pursuant to the Settlement Agreement on a quarterly basis during the Consultation Period.

110. **Quarterly Meetings.** The Plan, the Department, and the Consulting Team will meet telephonically, virtually, or in-person on a quarterly basis during the Consultation Period. The purpose of these meetings will be to provide a progress review and status update of the activities performed and outcomes pursuant to the Settlement Agreement.

Corrective Action Areas

111. The Plan and Consulting Team will focus on the following **Corrective Action Areas** in order to help ensure enrollees receive timely access to medically necessary behavioral health services and to aid the Plan's Behavioral Health Quality Assurance program in ensuring that effective action is taken to improve care where deficiencies are identified in service areas, including accessibility, availability, and continuity of care. The Corrective Action

Areas are not intended to be an exhaustive list of actions the Plan must take to address each area. Rather, they are intended to provide guidance and set the minimum actions the Plan must undertake. The Correction Action process is intended to be dynamic and subject to continued modification through the Corrective Action Work Plan process as needed to address the issues and deficiencies the Department has identified.

Corrective Action Area No. 1: Oversight

The Plan shall improve its Quality Assurance Program, including continuous performance review and enhanced oversight of the Medical Groups and external contracted providers to ensure timely access, network adequacy, continuity of care, level of care, and quality of care for behavioral health services. The Plan must also implement policies and procedures for intervention whenever necessary, including, for example, if the Medical Groups are unable to ensure that behavioral health care services are reasonably available to Plan enrollees. The corrective actions the Plan shall implement on this topic must include at minimum, the following:

A. The Plan shall create quality metrics and performance standards that are established and routinely monitored by the Plan and documented to ensure enrollees receive timely behavioral health appointments, as well as medically necessary behavioral health services, that are consistent with the standards under the Knox-Keene Act and regulations promulgated thereunder. Issues that are identified will be escalated appropriately and corrective action will be taken in a timely manner. (See Health & Saf. Code, §§ 1367.03, 1370, 1374.72, 1374.721; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.70, subd. (a)(3), 1300.70, subds. (b)(2)(G), 1300.70, subd. (b)(2)(H), 1300.74.72.)

B. The Plan shall ensure that it has full transparency of and access to all necessary policies, practices, standards, and data, including real-time data, from the Medical Groups and from external contracted providers to conduct the Plan's oversight and review of the Medical Groups and external contracted providers,

including, but not limited to, encounter data, appointment data, medical records, and claims information. (See Health & Saf. Code, § 1370; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.70, subd. (a)(3), 1300.70, subd. (b)(2)(G), 1300.70, subd. (b)(2)(H).)

C. The Plan shall improve its development of internal corrective action plans ("CAP"). The Plan shall develop a process to implement internal CAPs in a way that fully documents and analyzes the root cause of the issue to be corrected and sets forth clear corrective action interventions, including improvement benchmarks. When a CAP does not result in timely improved results, the Plan shall have a process, including associated documentation, that modifies the CAP to demonstrate enhanced analysis and intensified efforts. (See Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (d)(3).)

D. The Plan shall improve its measurement of behavioral health appointment access compliance. The Plan shall develop a measurement mechanism that identifies appointment requests where the resulting first offered appointment does not meet the timely access standards for behavioral health appointments. The Plan's measurement mechanism shall differentiate between and document all appointments where (1) an enrollee was offered an appointment within the timely access standards but chose an appointment outside the timely access standards; (2) those instances where an appointment within the timely access standards was not available or not offered to the enrollee, and the provider, or the health professional providing triage or screening services, did not note a non-detriment statement; and (3) those instances where an appointment within the timely access standards was not available or not offered to the enrollee, but the provider, or the health professional providing triage or screening services, did note a non-detriment statement. (See Health & Saf. Code, § 1367.03; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.67.2.3.)

E. The Plan shall fully implement clinical policies and procedures to ensure consistent treatment, and inter-rater reliability (IRR) across the Plan, Medical Groups, and external contracted providers. The clinical policies and procedures, including criteria and guidelines, shall be consistent with the clinical review standards set forth in the Knox-Keene Act and regulations promulgated thereunder. (See Health & Saf. Code, §§ 1374.72; 1374.721; Cal. Code Regs., tit. 28, § 1300.74.72.)

Corrective Action Area No. 2: Access

The Plan shall improve its procedures to ensure that its enrollees can access behavioral health appointments consistent with timely access standards. The corrective actions the Plan shall implement on this topic must include at minimum, among other things, the following:

A. The Plan shall develop and implement an improved policy and process to effectively monitor each enrollee's appointments, treatment plan, individualized behavioral health care needs, and care consistent with good professional practice, with the Plan intervening as necessary to ensure compliance. The Plan must provide a clearly defined and fully implemented policy and process to be uniformly applied across the Plan, all Medical Groups, Medical Group providers, and external contracted providers, to ensure that initial, follow-up, and rescheduled behavioral health appointment access complies with the timely access requirements, and is consistent with each enrollee's treatment plan, individualized behavioral health care needs, and the clinical criteria stated under the Knox-Keene Act and regulations promulgated thereunder. The policy and process shall ensure that the Plan requires the Medical Groups and external contracted providers to fully document in the enrollees' medical records the date and time the enrollee requested behavioral health appointments, the date and time of the first available appointment that was offered to the enrollee, the date

and time of the appointment the enrollee accepted, and if a statement of non-detriment or patient preference is documented in the enrollee's medical record. The policy and process shall further ensure that enrollees are provided with timely behavioral health services that are based on individualized determinations of medical necessity. (See Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subds. (a)(3), (b)(1), (b)(2)(G), (b)(2)(H).)

B. The Plan shall improve, for both Medical Group providers and external contracted providers, the processes for appointment booking and documentation related to behavioral health services, including, but not limited to, booking of initial and follow-up behavioral appointments within the timely access standards under the Knox-Keene Act and regulations promulgated thereunder. (See Health & Saf. Code, § 1367.03; Cal. Code, Regs., tit. 28, §§ 1300.67.2.2, subd. (b)(2).)

C. The Plan shall continuously assess whether the Medical Groups are performing their obligation to the Plan to ensure that behavioral health care services are available consistent with good professional practice and timely access standards to Plan enrollees. If the Plan determines that the Medical Groups are not performing these delegated functions, the Plan must intervene and take whatever steps necessary to ensure compliance. (See Health & Saf. Code, §§ 1367.03, 1370; Cal. Code Regs., tit. 28, §§ 1300.67.2.2; 1300.70.)

Corrective Action Area No. 3: Network and Referrals

The Plan shall improve the ability of its enrollees to access the Plan's network, including external contracted providers, for behavioral health services, and improve the ability of its enrollees to access out-of-network providers for behavioral health services in instances where the Plan's network cannot offer enrollees timely care. The corrective actions the Plan shall implement in this area must include at minimum the following:

A. The Plan shall review, monitor and participate in the process of issuing referrals to external contracted providers and out-of-network providers for behavioral

health services. The Plan shall participate and oversee the process of scheduling of behavioral health appointments with external contracted providers and out-of-network providers within the timely access standards required under the Knox-Keene Act and regulations promulgated thereunder. The Plan shall not, and must ensure that the Medical Groups do not, prohibit a referral to an external contracted provider based solely on a determination that the enrollee has a severe or chronic condition that requires care to be performed by Medical Group providers. (See Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code, Regs., tit. 28, § 1300.67.2.2.)

B. The Plan shall improve and oversee the collection of external contracted provider access data. The Plan's external contracted provider network shall be fully integrated into the Plan's behavioral health access monitoring plan, processes, systems, and reporting structures. The Plan shall ensure that enrollee appointment access when an enrollee is referred to an external network complies with timely access standards. The Plan shall ensure that the Plan has full transparency of and access to all necessary data from the external contracted providers so that the Plan can conduct its continuous, oversight, review, and intervention as necessary, including, but not limited to, encounter data, appointment data, medical records, and claims information. (See Health & Saf. Code, § 1367.03, subd. (f)(1); Cal. Code, Regs., tit. 28, § 1300.67.1, subd. (c).)

C. The Plan shall develop a process for identifying members who attempted, but were unable to, obtain timely and clinically appropriate behavioral health care services in-network and, as a result self-referred to an out-of-network provider. The Plan will develop a process for evaluating enrollee out-of-network claims for reimbursement. The terms of such reimbursement will be subject to agreement between the Plan and the Department. The Plan shall present the process

required by this paragraph to the Department no later than the due date for the first Quarterly Report, as provided in Paragraph 109 above.

Corrective Action Area No. 4: Grievance and Appeals

The Plan shall improve its grievance and appeals policies and procedures. The corrective actions the Plan shall implement on this topic must include at minimum, the following:

A. The Plan shall improve the Grievance and Appeals process by which enrollee grievances are acknowledged, adequately considered, and responded to within the timeframes required under the Knox-Keene Act and regulations promulgated thereunder. The Plan shall review its practice of referring appointment requests for which a timely appointment cannot be booked through the Grievance and Appeals review process, to ensure that this practice results in enrollees receiving appointments consistent with timely access standards separate from the time that it takes grievances to be resolved. The Plan's review shall develop processes to promptly address any enrollee grievance based, in part, on a complaint that the enrollee cannot schedule a timely behavioral health appointment. The Plan must implement a consistent procedure to ensure that all enrollees who are not offered timely appointments are reviewed for risk and their behavioral health care needs are met. (See Health & Saf. Code, §§ 1367.03, 1368, 1368.01; Cal. Code, Regs., tit. 28, §§ 1300.67.2.2, subd. (b)(2), 1300.68.)

B. The Plan shall develop a process through which all enrollee grievances regarding a delay or difficulty in obtaining a timely behavioral health appointment are routed to grievance coordinators specially trained in Department-regulated products and Knox-Keene Act and regulations relating to timely access. Although this group of grievance coordinators may primarily focus on Department-regulated products, the group of grievance coordinators may answer calls about health care products

licensed in other states, should the Plan choose to have them answer such calls. (See Health & Saf. Code, §§ 1367.03, 1368.)

Corrective Action Area No. 5: Future Strike Contingency Plans

The Plan shall develop a comprehensive contingency plan to be implemented in the event of future labor work stoppages that may result in cancellation of enrollee behavioral health appointments. The contingency plan shall include uniform processes for documentation of enrollee notification of appointment cancellation, and clinical review for prompt rescheduling consistent with enrollees' individual treatment needs. The contingency plan shall also create a uniform reporting structure for Plan oversight of appointment cancellations and/or rescheduling. (Health & Saf. Code, § 1367.03, subd. (a)(3).)

Corrective Action Area No. 6: Mental Health Parity

The Plan shall develop processes to ensure that the Plan is in compliance with all behavioral health parity laws. This shall include, but is not limited to, the Plan ensuring that enrollees receive appropriate treatment based on individualized determinations of clinical appropriateness, and regardless of the type or severity of the enrollees' behavioral health conditions. The Plan shall ensure that enrollees are not directed to behavioral health group therapy, classes, smartphone applications, or "one-size-fits-all" therapy alternatives without an individualized determination that such therapy, classes, applications, or alternatives are clinically appropriate for the enrollee's individual condition. The Plan shall ensure that enrollees do not face barriers to scheduling behavioral health appointments that do not exist for non-behavioral health appointments. (Health & Saf. Code, § 1374.72, subd. (a).)

Corrective Action Area No. 7: Member Communications and Advertising

The Plan shall conduct a comprehensive review of all Plan communications and representations to enrollees, including any related policies, procedures, and training materials, regarding behavioral health services including, but not limited to, advertising to enrollees and the general public, to ensure accuracy and completeness of information provided. This shall include communications and representations regarding the ability of enrollees to obtain

individual and group behavioral health therapy, the ability of enrollees to obtain referrals to external contracted providers and out-of-network providers, and regarding alternatives to behavioral health therapy such as classes and smartphone applications. This shall also include information about changes the Plan will implement as the result of this Settlement Agreement and Corrective Action Work Plan, and will also include review of communications to enrollees made by the Medical Groups and external contracted providers. (Health & Saf. Code, § 1360, subds. (a) & (a)(2).)

Corrective Action Area No. 8: Continuous Detailed and Comprehensive Review

The Plan shall engage in a systemic evaluation of all existing programs, processes, mechanisms, and policies and procedures by which enrollees access or receive behavioral health services, including but not limited to Connect 2 Care, eConsult, Tridiuum, Tapestry, Ableto, and VADAPT. In addition, the Plan shall engage in a systemic evaluation of how enrollees access urgent behavioral health care services, including the availability of the Medical Groups and external contracted providers to offer urgent and emergent behavioral health services. The Plan shall also continuously review whether the Medical Groups are appropriately performing the delegated services, compliant with the Knox Keene Action and regulations promulgated thereunder. (See Health & Saf. Code, §§ 1367, subd. (j), 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subd. (a)(3).)

Deliverables/Benchmarks

112. The Plan and the Consulting Team shall complete the draft Corrective Action Work Plan by February 1, 2024. Upon completion of the draft Corrective Action Work Plan, the Plan and the Consulting Team shall submit the Corrective Action Work Plan to the Department for review. The Department shall provide any comment or feedback on the draft Corrective Action Work Plan within 30 days of receipt from the Plan. The Plan and the Consulting Team shall then have an additional 30 days to provide any response to the Department's feedback or comments.

113. Additional benchmarks, deliverables, and deadlines will be established as part of the Corrective Action Work Plan.

114. As acknowledged above, the Department's investigation in connection with the 2022 Non-Routine Survey is ongoing. It is the Parties' intention that this Settlement Agreement incorporates all deficiencies, factual findings, and corrective actions related to the subject matters covered by the 2022 Non-Routine Survey Final Report. The Parties acknowledge that if as the result of the 2022 Non-Routine Survey Final Report, the Department identifies additional deficiencies that are not already addressed as part of the Corrective Action Areas or the Corrective Action Work Plan, the Department has authority to require the Plan and Consulting Team to supplement or amend the Corrective Action Work Plan to address such deficiencies. Any additional corrective actions will be incorporated into and become a part of this Settlement Agreement.

Department Discretion

115. At the Plan's request, the Department has the discretion, with the Consulting Team's recommendation and/or input, to revise or modify benchmarks, deadlines, and Deliverables set forth in the Corrective Action Work Plan. Such discretion may be exercised if the Plan fails to achieve any of the stated benchmarks, deadlines, or Deliverables, despite the Plan's best efforts in working with the Consulting Team, or in the event there is a change to state or federal law impacting the requirements of this Settlement Agreement.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

ACCEPTANCE

Dated: October 11, 2023 Kaiser Foundation Health Plan, Inc.

/Original Signed/
Deborah Espinal, PhD
Vice President, Enterprise Regulatory Services
Kaiser Foundation Health Plan, Inc. & Hospitals

I have read and fully discussed with the Plan the terms and conditions and other matters contained in the above Stipulated Settlement and Agreement. I approve its form and content.

Dated: October 11, 2023 Sheppard, Mullin, Richter & Hampton, LLP

/Original Signed/
Moe Keshavarzi
Attorney for Kaiser Foundation Health Plan, Inc.

Dated: October 11, 2023 DEPARTMENT OF MANAGED HEALTH CARE

/Original Signed/
Sonia R. Fernandes, Complainant
Deputy Director | Chief Counsel
Office of Enforcement