NUHW NATIONAL UNION OF HEALTHCARE WORKERS

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February 28, 2024

Mary Watanabe, Director
Dan Southard, Chief Deputy Director
Sarah Ream, General Counsel
Sonia Fernandes, Deputy Director, Office of Enforcement
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Dear Ms. Watanabe, Mr. Southard, Ms. Ream, and Ms. Fernandes:

On behalf of the National Union of Healthcare Workers (NUHW), I am writing to provide evidence of Kaiser Foundation Health Plan's ("Kaiser") ongoing violations of California and federal laws with respect to its behavioral health services. NUHW requests action by DMHC to correct Kaiser's violations and protect the rights of California consumers.

I. SUMMARY: Founded in 2019, Path Mental Health (Path) is a provider network composed of more than 8,000 licensed non-physician behavioral health therapists ("therapists") and psychiatric nurse practitioners who provide outpatient therapy to individuals, couples, and families for patients ages five years and older. Path, which only provides virtual care, contracts with more than two dozen health plans operating in 48 states including Aetna, Anthem Blue Cross, Blue Cross/Blue Shield, Cigna, Health Net, Optum, and United Healthcare.[1]

On February 5, 2024, Path rebranded the company as "Rula Health."[2] This complaint subsequently refers to the company as "Rula." Rula is neither licensed nor accredited for utilization management.

In December 2022, Rula added Kaiser Foundation Health Plan of Southern California as a payor (Exhibit A). However, unlike Rula's other payors, Kaiser required Rula to perform "Clinical Care Reviews" (CCR) for Kaiser enrollees to "determine if a client meets medical necessity criteria for ongoing care based on [therapists'] documentation in the medical record." Its CCRs, performed by Rula's Quality Team (that is, not enrollees' treating therapists), "take place by default for all clients covered by Kaiser once the client has their **12th session**." During the CCR process, Rula's Quality Team "evaluate[s] elements identified by Kaiser that indicate the need for ongoing care. The CCR includes review of the initial assessment and most recent progress

[1] https://www.rula.com/faq/

[2] Rula Health. "Path Rebrands to Rula Health, Focuses on Improving Mental Healthcare Outcomes." PR Newswire. February 5, 2024. Accessed at: https://www.prnewswire.com/news-releases/path-rebrands-to-rula-health-focuses-on-improving-mental-healthcare-outcomes-302052844.html

notes with attention on the treatment plan and outcome measures." Rula's CCR process "is only in place for clients covered by Kaiser…" If ongoing care is determined to be medically necessary, Rula "will obtain a re-referral from Kaiser for an additional 10 sessions." The CCR process "will repeat itself as needed with subsequent reviews occurring after the **7th session** of the re-referral time period." If Rula determines that ongoing care is not medically necessary, "Kaiser will not pay for care that has been determined to be medically unnecessary based on the Clinical Care Review…"

With respect to medical necessity determinations, Rula makes no mention of using the state-mandated medical necessity criteria – namely, the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Instead, Rula's documents indicate that such determinations are made by using enrollees' self-assessment scores on tools such as PHQ, GAD and AUDIT-C. A keyword search of Rula's online "provider portal" and electronic resource library for Rula's therapists produces no results for the following terms: "LOCUS," "CALOCUS," "CASII" AND "ASAM."[3]

If Kaiser enrollees' care episodes are terminated due to the CCR process, enrollees can continue to receive care from Rula if they self-pay for their treatment.

In January 2024, Rula's CCR process for Kaiser enrollees continued in place with virtually all of the same features that were present in December 2022, according to webinars, written documents, and updated policies that Rula disseminated to its therapists at the beginning of 2024.

Rula's CCR policy (approved by Rula's COO and last reviewed in May 2023) notes that CCRs "are always concurrent reviews," a form of utilization management intended in part to determine whether patients meet medical necessity criteria to receive ongoing care. The purpose of the CCR is "to determine if there is a clinical need for ongoing care."[4] Rula ***only*** applies its CCR process to Kaiser enrollees.[5] "Kaiser will not pay for care that has been determined to be not clinically indicated based on the Clinical Care Review and Rula may not reimburse providers who continue to provide services following a determination that the episode of care is not clinically indicated."[6]

According to Rula's January 2024 CCR webinar led by its Clinical Review Manager, Vanessa Barrientes, Rula does not inform Kaiser enrollees of adverse medical necessity determinations, does not note any adverse medical necessity determinations in enrollees' medical charts, and does not provide enrollees with any due process rights. (Exhibit C)

Kaiser is violating multiple provisions of California law, including precise provisions for which it was cited in 2023 and which are detailed in Kaiser's October 2023 settlement agreement with DMHC. First, Kaiser appears to have impermissibly delegated utilization management to a third party that is neither licensed nor accredited to do so.

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[3] This library is accessible at https://therapistsupport.rula.com/

[4] Rula. Clinical Care Review at Rula. P. 1. (Exhibit F)

[5] Rula. Clinical Care Review at Rula. P. 1. (Exhibit F)

[6] Rula. Clinical Care Review at Rula. P. 2. (Exhibit F)

Second, Kaiser has reportedly directed Rula to use illegal criteria to perform improperly delegated medical necessity reviews for Kaiser enrollees. California Health & Safety Code § 1374.721 requires health plans to use state-mandated medical necessity criteria. There is no evidence that Kaiser or its contractor are using these criteria for Kaiser enrollees under Rula's care.

Third, Kaiser enrollees are not informed that their care episodes are subjected to utilization management and enrollees are not provided adverse benefit determination notices and due process rights.

Fourth, Rula's concurrent reviews violate federal and California parity laws since the reviews are disparately applied to outpatient psychotherapy at pre-set frequencies. Kaiser does not subject the overwhelming bulk of its outpatient medical/surgical services to such reviews, let alone at such frequencies.

NUHW requests that DMHC immediately hold Kaiser accountable to the full extent of the law and that it take a number of steps, specified at the end of this complaint, to protect the health and interests of Kaiser enrollees.

II. EVIDENCE

Exhibit A: Rula, Email to Rula's providers with subject line of "Process Change: Clinical Care Review," Sent to Providers on December 5, 2022.

In this email, Rula announces that it has added Kaiser as "a new insurance partner." It notes that Kaiser – unlike other health plans that contract with Rula – requires Rula to perform medical necessity determinations of Kaiser enrollees after enrollees' 12th treatment sessions in order for enrollees to continue receiving Kaiser coverage for treatment of their mental health and/or substance use disorders (MH/SUDs).

Excerpts from Exhibit A include the following:

> Seeing a client covered by Kaiser will feel almost exactly the same for you as any other client. However, there is one exception that we want you to be aware of as you begin the treatment relationship. Kaiser provides an initial outpatient therapy referral from the client's PCP for up to 16 sessions. When additional sessions are determined to be medically necessary beyond 16 visits, we are required to obtain a new referral from Kaiser to request an additional 10 sessions to ensure continuity of care in treatment…
>
> In compliance with the requirements from Kaiser, Path is implementing a Clinical Care Review (CCR) process that will operate in the background of your practice… A CCR is required for all clients covered by Kaiser who have had at least 12 sessions at Path… The CCR will determine if a client meets medical necessity criteria for ongoing care based on your documentation in the medical record… A

licensed Clinical Care Reviewer who is a member of the Path Quality Team will evaluate elements identified by Kaiser that indicate the need for ongoing care. The CCR includes a review of the initial assessment and most recent progress notes with attention on the treatment plan and outcome measures… Path will obtain a re-referral from Kaiser for an additional 10 sessions and enter this information into the record. This process will repeat itself as needed with subsequent reviews occurring after the 7th session of the re-referral time period… Kaiser will not pay for care that has been determined to be medically unnecessary based on the Clinical Care Review, however a client may continue to receive services if they would like to pay cash ($120/individual session). Clients should contact Support to make these arrangements.

Exhibit B: Rula, "Clinical Care Review Policy," May 15, 2023.[7]

Excerpts from Exhibit B include the following:

> This policy develops a standardized clinical care review process to assess and make a determination of the need for ongoing care for a patient seen by a Group provider…
>
> *Clinical care review (CCR):* a standardized process of review of a medical record by a trained, qualified, independently licensed social worker, psychologist, marriage and family therapist or professional counselor with the clinical expertise and training to conduct an evaluation of documentation. The reviewer will not be associated with the patient so as to provide an unbiased evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services…
>
> C. Clinical care reviews are always concurrent reviews which are completed during the patient's course of treatment. There are two portions of concurrent reviews that are used to make a determination:
>
> 1. A patient-level automated report based on quantitative information captured during the course of treatment; and
> 2. A standardized qualitative assessment of medical necessity that is completed by a clinical care reviewer using the Clinical Care Review Form.

[7] PATH. Clinical Care Review Policy, Policy Number 309. Approved by Paul Vogelman, COO. Effective Date 8/31/2022. Date of Last Review 5/15/2023. Available at https://therapistsupport.rula.com/hc/en-us/articles/22347909097115-Clinical-Care-Review-Policy Captured on 2-12-2024.

Concurrent review is a type of utilization management, the purpose of which is "to put an oversight process in place that permits the scrutiny of the type of care being delivered, the necessity for that care, and the level and setting of that care."[8]

Exhibit C: Rula, Video of a Rula webinar published on Rula's YouTube station entitled "Kaiser Clinical Care Review Overview," January 17, 2024. Available at https://www.youtube.com/watch?v=zstlMmdfX_8

On January 17, 2024, Rula conducted a 30-minute live webinar for Rula providers regarding its CCR process for Kaiser enrollees. Rula recorded the webinar, posted it on Rula's YouTube station, and, on January 19, 2024, sent an email to Rula providers with a link to the recorded webinar. (Exhibit C)

The webinar's only presenter and speaker was Vanessa Barrientes,[9] who described herself as an LPC in Texas whose Rula job title is "Clinical Review Manager." In the video, Ms. Barrientes noted that she also manages Rula's Care Coordination Team. Other Rula personnel who were present during the webinar include Jessie Nelson, LPC (Senior Quality Manager), Michelle Toliver, LMHC (Clinical Care Reviewer), and Jordan Pettigrew (Senior Clinical Operations Manager).[10]

The first half of the webinar consisted of Ms. Barrientes presenting a powerpoint presentation describing Rula's CCR process. In the second half, Ms. Barrientes responded to viewers' questions typed in the webinar's chat room. The webinar's viewers were Rula therapists.

The following are my notes regarding some of the video's content. Time stamps from the video are indicated in parentheses.

> The only Rula clients who receive clinical care reviews to determine if there is a clinical need for ongoing care are "clients covered by Kaiser Southern California" (2:30 min). Kaiser will not pay for any care that takes place after a Rula CCR determines that ongoing care is not needed (12:00 min).
>
> When Kaiser enrollees are terminated due to the CCR process, self pay is an option for them (16:25 min).

[8] Giardino AP, Wadhwa R. Utilization Management. [Updated 2023 Jul 10]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK560806/

[9] A search of Texas licensure records identifies a Vanessa Elaine Barrientes residing in Bexar, Texas who is licensed to practice in Texas as a "Licensed Professional Counselor" (LPC). (Texas License Number 73633. Texas Behavioral Health Executive Council. Online searches available at https://www.bhec.texas.gov/verify-a-license/index.html) According to records maintained by the California Department of Consumer Affairs, she is unlicensed to practice in California.

[10] Neither appears to be licensed to provide behavioral health therapy in California. Ms. Toliver is licensed to work in Massachusetts, where she lives, according to licensure records and her LinkedIn profile.

"Question: Are clients going to be updated on the decision [of a CCR] so that they know what their session charge will be?" Ms. Barrientes: "Clients are not notified of the decision… We don't notify them." (15:35 min)

"Question: Does PATH place a note in the patient's chart? Ms. Barrientes: "No, we do not… We don't notify and we're not gonna put in the chart if a clinical care review was done and clinical need was not present..." (16:35 min)

Ms. Barrientes: Clients shouldn't have questions about determinations that an episode of care is medically unnecessary and consequently has been terminated, and "they may not need to even know about this…" (12:30 min)

"Kaiser provides an initial outpatient therapy referral from the client's PCP for up to 16 sessions. Clients may continue to receive care as long as documentation reflects clinical need for treatment." The initial CCR takes place at approximately the 13th session and then every 10 sessions thereafter.

What documentation is reviewed during a CCR? Ms. Barrientes: Functional impairments, "whether interventions are targeted to impact functional impairments," "outcome measure changes that indicate a need for ongoing care," etc. Ms. Barrientes also discusses Kaiser's use of PHQ and GAD scores in determining need for ongoing care (23:55 min).

Question: Can a clinician opt out of serving clients associated with Kaiser?" Ms. Barrientes: You can. There are steps you can take. Please be in touch with our team (17:35 min).

Question: Is this for all clients or just for Kaiser clients? Ms. Barrientes: This is only for Kaiser clients in Southern California (19:30 min).

PATH is not currently doing a CCR process for non-Kaiser clients (25:25 min).

Question: How many Kaiser enrollees have had their Kaiser coverage withdrawn as a result of CCRs? Ms. Barrientes: Rula has been authorizing additional care sessions for more than 50% of the clients who undergo a CCR (23:25 min).

Exhibit D: Rula, Email to Rula's therapists with unknown subject line, Sent to Providers on January 19, 2024.

The entirety of the email message is presented below:

> On Friday, January 19, 2024, 6:25 PM, quality@pathccm.com <quality@pathccm.com> wrote:
> Hi [redacted]!
>
> We wanted to follow up after our Kaiser Clinical Care Review webinar on January 17th, 2024 to share some information that we hope you'll find helpful.

During the session, we discussed:

- The purpose and importance of clinical care reviews at Path
- How the CCR process supports therapists in delivering ongoing care
- The role of Clinical Care Reviewers in determining medical necessity
- Insights into the CCR process and answers to common questions

You can watch the full recording of our initial session here and review in written format the answers to commonly asked questions here.
If you have any additional questions or feedback, please email us at quality@pathccm.com

As always, thank you for the work you do to support Path clients.

Wishing you a great start to the New Year,
Path Quality

Exhibit E: Rula, "Session Q&A - Demystifying the Clinical Care Review," Created November 17, 2023.[11]

Exhibit D contains hyperlinked text ("answers to commonly asked questions here") that links readers to a five-page document on Rula's publicly accessible googledrive with a filename of "Session Q&A – Demystifying Clinical Care Review" and a document title of "Demystifying the Clinical Care Review Process: *Q&A." The document's title is followed by parenthetical phrase stating: "This list is inclusive of all questions over time from each monthly CCR session." According to the file's properties, it was created on November 17, 2023.

The following are excerpts from Exhibit E:

Q: Is a provider able to opt out of Kaiser clients from Path if FT for Kaiser?
A: No, providers cannot opt out of providing services to clients based on their insurance type, unless there is an identified conflict of interest…

Q: I discharged a client with Kaiser insurance but they've recently reached out to me about returning to treatment. How can I coordinate this?
A: Have the client reach out to billing@pathccm.com to confirm if their Kaiser referral on file is still active to cover future sessions. If referral is active and they re-start sessions, their session count will resume and the chart will come up for review accordingly. For more information about when a chart is reviewed, reference the CCR article in the therapist help center, link here.

Q: Do all providers get reviewed?

[11] Available at the following URL. Accessed on February 26, 2024.
https://docs.google.com/document/d/1LnLlZGU5AmB3tBN8-1CPgbSyLqCoTj4gBDzTRry9uNA/edit

A: No. Currently clinical care reviewers are only applicable to clients in CA with Kaiser coverage only (Sic) therapists in CA who are credentialed with Kaiser are applicable for a CCR. Please see here for more information.

Q: Is it possible to have this training and other training to be recorded in the future?
A: A previous recording of the initial session which covered the same content/slides as today's current session can be found here. These sessions will reoccur monthly and will go over the same information…

Q: What's the limit for clients with severe axis II comorbidity and clients with chronic severe mental illness?
A: Further care is determined by your documentation of the client's symptoms and functional impairments.

Exhibit F: Rula, "Clinical Care Review at Rula," Created May 15, 2023.[12]

Exhibit F is a three-page document with a filename of "Clinical Care Review at Rula" that is located on Rula's googledrive, which is publicly accessible. Excerpts include the following:

What is Clinical Care Review?
A Clinical Care Review (CCR) is a qualitative and quantitative review of documentation in a client's record to determine if there is a clinical need for ongoing care. You can read our CCR policy here.

Who completes the Clinical Care Review?
Rula employs licensed Clinical Care Reviewers who are members of the Quality Team. Each reviewer has more than 5 years of clinical experience and has spent a minimum of 3 years engaged in peer review or utilization management.

Which clients receive a Clinical Care Review?
At present, the CCR process is only in place for clients covered by Kaiser SoCal.

When does a Clinical Care Review take place?
Reviews are completed prior to the 16th visit (typically after the 13th session) and then every 10 visits after that while a client is engaged in care (i.e., session #13, 23, 33, 43, etc.).

…**How will I know if ongoing care has been deemed clinically indicated based on my documentation?**
Your clinical work drives this decision based on what is documented in the client's record. If you don't hear from Rula, continue to treat your client as needed. The Clinical

[12] Available at https://docs.google.com/document/d/1JwvO8Iz8t1iT1Q1y8NfQ-Hr2bT5t-crwHA91uTUbwpk/edit Accessed on February 15, 2024.

Care Review process will repeat itself continuously in the background of your practice, and will rely on your notes regarding the client's needs and the treatment plan (as described above). No action is needed.

If ongoing care is not clinically indicated:

- You will be notified via email of this determination.
- You are expected to discuss discharge from care with your client.
- The email notification will include aftercare resources to review with your client.

Here are some of Rula's reasons for determining clinical justification is not present:

- Documentation reflects that the client has or is approaching achievement of their goals
- The client requires a higher level of care
- The purpose of care is not directly related to improving symptoms and/or functional impairment specified on the treatment plan

…Kaiser will not pay for care that has been determined to be not clinically indicated based on the Clinical Care Review and Rula may not reimburse providers who continue to provide services following a determination that the episode of care is not clinically indicated.

As far as the qualifications of Rula's Clinical Care Reviewers, Exhibit B describes their qualifications differently than does Exhibit D. Exhibit B says a Clinical Care Reviewer is "…a trained, qualified, independently licensed social worker, psychologist, marriage and family therapist or professional counselor with the clinical expertise and training to conduct an evaluation of documentation."

Exhibit G: Rula, "MBC Rollout – Provider FAQ," Created August 9, 2022.[13]

Exhibit G is a four-page document with a filename of "MBC Rollout – Provider FAQ" and a document title of "Measuring Client Outcomes: Path Provider FAQ." It is located on Rula's googledrive, which is publicly accessible. It discusses Rula's use of GAD, PHQ, AUDIT-C and the Columbia Suicide Severity Screening Scale to measure enrollees' self-reported symptom severity, which is one of the criteria used by Rula to evaluate enrollees' needs for continuing treatment.

[13] Available at https://docs.google.com/document/d/1tHFmv2Mp1iVBegv0u8Ae9R3jF4C11zwve4XmCkMHEPU/edit Accessed on February 26, 2024.

Exhibit H: Rula**, "**Outcome measures at Path (Nov 2022)."[14]

Exhibit H is a 12-slide presentation prepared by Cynthia Grant, Rula's Head of Clinical Care. It has a filename of "Outcome measures at Path (Nov 2022)" and a document title of "Measuring Client Outcomes." The presentation, which is available on Rula's publicly accessible googledrive, discusses Rula's use of tools such as GAD, PHQ, AUDIT-C and the Columbia Suicide Severity Screening Scale to measure enrollees' self-reported symptom severity.

III. LAWS AND ANALYSIS

During its recent enforcement investigation, DMHC documented very serious and systemic violations committed by Kaiser and detailed in the October 2023 settlement agreement between DMHC and Kaiser. In short, Kaiser violated many areas of the laws governing the responsibilities and operational areas discussed in this complaint, including quality assurance, delegation oversight, medical necessity and level-of-care determinations, mental health parity and medical-record documentation and retention practices. The following are excerpts from the settlement agreement:

- "[T]he Department has observed that the Plan… 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." (paragraph 43)

- "[T]he Plan lacks sufficient oversight of the Medical Groups." (paragraph 39) "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." (17)

- "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." (paragraph 18)

- During DMHC's 2023 enforcement investigation, Kaiser did not provide evidence or documentation "that would reflect implementation or use of the appropriate clinical criteria" required by California law for making medical necessity determinations. Instead, medical records reviewed by DMHC indicated that Kaiser illegally uses enrollees' "self-assessment scores" including PHQ, GAD, AOQ and AUD. (paragraphs 37-38)

[14] Available at https://docs.google.com/presentation/d/1fL7wqNPEVBKDL6n8ZXc32g_frQTWNzxF6WN9pOYGoP0/edit#slide=id.g145327fefca_0_47 Accessed on February 26, 2024.

- "[T]he 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." (paragraph 41)

- "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." (paragraph 40)

- "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." (paragraph 75)

This complaint documents additional instances of Kaiser's violation of many of these same provisions. First, Kaiser appears to have impermissibly delegated utilization management to a third party that is neither licensed nor accredited to do so.

Second, Kaiser has reportedly directed Rula to use illegal criteria in performing medical necessity determinations for Kaiser enrollees. California Health & Safety Code § 1374.721 requires health plans to use state-mandated medical necessity criteria. There is no evidence that Kaiser or its contractor are using these criteria for Kaiser enrollees under Rula's care.

Third, Kaiser enrollees are not informed that their care episodes are subjected to utilization management and enrollees are not provided adverse benefit determination notices and due process rights.

Fourth, Rula's concurrent reviews violate federal and California parity laws since the reviews are disparately applied to outpatient psychotherapy at pre-set frequencies. Kaiser does not subject its outpatient medical/surgical to such reviews, let alone at such frequencies.

IV: REQUEST

NUHW requests that DMHC take immediate action to enforce our state's laws and to prevent ongoing harm to California residents.

Given that Rula's CCR process, which was implemented upon Kaiser's orders, is illegal, we request that DMHC order Kaiser to immediately cease the Rula CCR process.

Second, we request that DMHC order Kaiser to perform a retrospective review of every Kaiser enrollee whose care episodes at Rula were terminated by Kaiser's CCR process and to notify any enrollees whose treatment was illegally terminated by Rula. Such enrollees should receive Kaiser-funded diagnostic assessments by licensed therapists using legally mandated medical necessity criteria to determine their current clinical needs. For enrollees whose care episodes

were terminated and who self-paid for continuing care, we request that DMHC require Kaiser to reimburse enrollees for such care, plus interest.

Third, given the systemic and serial nature of Kaiser's failure to adequately oversee its provider network and to perform routine quality assurance functions, we request that DMHC launch investigations into all of the providers comprising Kaiser's external mental health provider network, that the investigations be performed by DMHC staff, and that the investigation be funded by Kaiser. In our review of the settlement agreement between Kaiser and DMHC of October 2023, we note that Kaiser made false representations to DMHC investigators during the investigation. These false statements were only discovered after DMHC conducted its own review of Kaiser's medical records and other documentation. For example, the agreement notes the following:

> 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… 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. (paragraph 37)

Given Kaiser's track record of deception, it would be irresponsible to trust Kaiser to investigate itself. Consequently, we request that DMHC require Kaiser to fund investigations to be performed by DMHC staff.

Fourth, we request that the violations described in this complaint be integrated into the corrective action process mandated by the settlement agreement, with the requirement that Kaiser report on remedial actions and its performance in quarterly reports to DMHC and in quarterly meetings with DMHC officials. Given the large numbers of Kaiser enrollees treated by Kaiser's external mental health providers, we request that DMHC establish a rapid timeframe by which Kaiser is required to remedy its violations.

Lastly, given that the violations described in this complaint identify additional harm to California consumers not contemplated by the settlement agreement, we request that DMHC impose additional fines and penalties on Kaiser. As noted in the settlement agreement, Kaiser has repeatedly violated state law since 2006. Only aggressive action by DMHC, including stiff penalties, will dissuade it from continuing to violate our laws and enrollees' rights. NUHW stands ready to assist.

Please contact me with any questions or concerns.

Sincerely,

Fred Seavey

cc: Rob Bonta, California Attorney General
Mike McGuire, Senate President Pro Tempore
Robert Rivas, Speaker of the Assembly
Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Scott Wiener, Chair, Senate Select Committee on Mental Health
Richard Roth, Chair, Senate Committee on Health
Mia Bonta, Chair, Assembly Committee on Health
Don Moulds, CalPERS
Dr. Julia Logan, CalPERS

EXHIBIT A

From: Path Quality Team <quality@info.pathmentalhealth.com>
To:
Sent: Monday, December 5, 2022
Subject: Process Change: Clinical Care Review

QUALITY & COMPLIANCE

Hi XXXXXX,

As you may know, Path recently added a new insurance partner in Kaiser Permanente (Southern California region). We are thrilled that this relationship will allow us to provide access to care for so many people in need of services. Additionally, by expanding our payor relationships, this will help ensure that Path is able to consistently fill your calendar with the types of clients you like to serve.

Seeing a client covered by Kaiser will feel almost exactly the same for you as any other client. However, there is one exception that we want you to be aware of as you begin the treatment relationship. Kaiser provides an initial outpatient therapy referral from the client's PCP for up to 16 sessions. When additional sessions are determined to be medically necessary beyond 16 visits, we are required to obtain a new referral from Kaiser to request an additional 10 sessions to ensure continuity of care in treatment. 65% of all people seen by a Path therapist have 16 sessions or less. Clients seen at Path have an average of 10.6 sessions.

We have developed a plan to allow this process to take place without an interruption in services. However, this also means that you'll need to pay special attention to your documentation to ensure that your notes and the treatment plan demonstrate medical necessity for care so that there is no interruption in services. You'll be notified in the new client appointment email that a new client is covered by Kaiser.

Here's how this process will work

In compliance with the requirements from Kaiser, Path is implementing a Clinical Care Review (CCR) process that will operate in the background of your practice. Some key points associated with the process include:

1. A CCR is required for all clients covered by Kaiser who have had at least 12 sessions at Path. The total count of sessions is across all providers and all modalities (i.e., rematches, individual, couples and family therapy all 'count' towards the total number of sessions).
2. A CCR will automatically take place by default for all clients covered by Kaiser once the client has their **12th** session. No action is needed on your part.
3. The CCR will determine if a client meets medical necessity criteria for ongoing care based on your documentation in the medical record. Details of what is being reviewed can be found here.
    - A licensed Clinical Care Reviewer who is a member of the Path Quality Team will evaluate elements identified by Kaiser that indicate the need for ongoing care. The CCR includes a review of the initial assessment and most recent progress notes with attention on the treatment plan and outcome measures..
4. A review decision will be made no later than the **14th** session. You will be notified of the decision via email prior to the 14th session.

If ongoing care is medically necessary based on the CCR:

- Path will obtain a re-referral from Kaiser for an additional 10 sessions and enter this information into the record.
- This process will repeat itself as needed with subsequent reviews occurring after the 7th session of the re-referral time period.
- No action is needed on your part. You will continue to work with the client and keep your notes and treatment plan up to date to demonstrate medical necessity.

If ongoing care is determined to be medically unnecessary:

(e.g., documentation reflects that the client has or is approaching achievement of their goals, the problem is unlikely to be resolved at the outpatient level of care, the purpose of treatment is not directly related to improving symptoms and functional impairment, etc.)

- Path will notify you via email and place a pop-up memo on the client chart.
- You will be provided with details of how to file an appeal if you disagree with the CCR decision. Details with how to file an appeal will be included in the email notification sent to you.
- In most of these cases, you should wind down treatment with a plan to discharge the client from care within the few remaining sessions. You will need to have a conversation with the client about ending treatment.
- Kaiser will not pay for care that has been determined to be medically unnecessary based on the Clinical Care Review, however a client may continue to receive services if they would like to pay cash ($120/individual session). Clients should contact Support to make these arrangements..
- Path will assign you new clients to fill your caseload as clients complete care if your calendar has slots available for new clients and you have not paused yourself.

Note: Medical necessity and a billable diagnosis are required for all clients covered by commercial insurance. However, the initiation of a CCR at the 12th session is only in place for clients covered by Kaiser at this time.

In the upcoming weeks you will see an improvement in our process with the implementation of automated emails notifying you when a client is undergoing CCR, and whether ongoing care is deemed medically necessary.

A common misperception among clinicians is that Kaiser “limits” sessions to 16 visits. This is inaccurate. A client will remain in care as long as medical necessity is captured following a CCR and we have obtained a new referral number issued by Kaiser.

We hope this email gives you the information you need to understand why, what, when, and how this process will work for clients seen at Path who are covered by our contract with Kaiser. We know that some clinicians are very familiar with treatment reviews such as this process, whereas this may be new for others. We have a number of resources available to offer support and discussion. A Clinical Quality Coach attends all Provider Office Hour

sessions and is available as a resource to talk through questions. You can find the date, time and links to these meetings that take place 3x per week here. We encourage you to attend a meeting if you would like to learn more. You can also review our resource document for more details.

Want to know more about how to document medical necessity to ensure your clients are eligible for ongoing care?
Check out the resources listed in this document for more info.

If you have questions specific to the process, please contact the Quality Team at quality@pathccm.com. If you have any general questions, please reach out to support (support@pathccm.com or 323-676-7425).

Thank you for all you do to care for your clients,

EXHIBIT B

Rula

Search questions, keywords, topics

Getting Started Account Settings Client Management Using the E

Clinical Care Review Policy

Follow

Policy: Clinical Care Review	
Policy Number: 309	Policy Section: Quality
Owner: Cynthia Grant	Approved By: Paul Vogelman, COO
Effective Date: 8/31/2022	Date of Last Review: 5/15/23

SUD Specialty Group -- CA; Mental Health Specialty Group, P.A.; Mental Health Specialty Group NJ, PC; and Mental Health Specialty Group KS, P.A. (collectively, the "Group") contracts with Path CCM, Inc. d/b/a Rula Health ("Rula") for management and administrative support services. This policy applies to the Group and Rula.

Policy Statement

This policy develops a standardized clinical care review process to assess and make a determination of the need for ongoing care for a patient seen by a Group provider. The purpose of clinical care review is to facilitate the provision of quality, efficient behavioral health care services to patients and providers through monitoring, evaluating, measuring, and directing processes and behaviors which impact the delivery of services.

Applicability

This policy applies to team members who provide treatment services to patients. For purposes of this policy, the Group's and Rula's team members include individuals who would be considered part of the workforce such as employees, independent contractors, business team members, and other persons whose work performance is under the direct purview of Rula or the Group's business practices.

Definitions

Clinical care review (CCR): a standardized process of review of a medical record by a trained, qualified, independently licensed social worker, psychologist, marriage and family therapist or professional counselor with the clinical expertise and training to conduct an evaluation of documentation. The reviewer will not be associated with the patient so as to provide an unbiased evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services.

Provider: an individual who is qualified by licensure and experience to provide services to patients and who is employed or contracted by the Group to provide those services

Medical necessity: health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, and that are: (a) in accordance with generally accepted standards of clinical practice; (b) clinically appropriate, in terms of type, frequency, extent, and duration, and considered effective for the patient's illness; and (c) not primarily for the convenience of the patient or Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic results as to the diagnosis or treatment of that patient's illness.

Generally accepted standards of medical practice: standards that are based on credible scientific evidence published in peer-reviewed clinical literature generally recognized by the relevant therapeutic community, Provider specialty association recommendations, and the views of Providers practicing in relevant clinical areas and any other relevant factor.

Policy

1. Clinical care review protections.

1. Clinical care reviews are a quality activity, the confidentiality of which is protected by HIPAA. Clinical care reviews are used for ongoing quality improvement efforts related to the necessity, appropriateness, or quality of services rendered to a patient.
2. The record of the clinical care review, including but not limited to, the associated clinical care review form, the data collected, and the resulting reports, findings, and conclusions are confidential and are not part of the designated record set.
3. As part of the quality process, payers may review clinical care review determinations upon request.

B. Clinical care reviews may be completed or requested for various reasons,

including, but not limited to:

1. Findings from a peer review or chart audit;
2. A patient, family member or patient advocate request;
3. A complaint or Grievance brought to the attention of the Quality team;
4. A provider request for ongoing services;
5. A payer request;
6. Group finding of a patient's lack of progress over two consecutive measurements;
7. Anytime service delivery concerns are brought to the attention of the Quality team.

C. Clinical care reviews are always concurrent reviews which are completed during the patient's course of treatment. There are two portions of concurrent reviews that are used to make a determination:

1. A patient-level automated report based on quantitative information captured during the course of treatment; and
2. A standardized qualitative assessment of medical necessity that is completed by a clinical care reviewer using the Clinical Care Review Form.

D. Documentation of review and results

1. Clinical care review findings will be documented in a standardized format using the Clinical Care Review Form.
2. Results of clinical care reviews will be sent to the appropriate party for the purpose of quality/practice improvement and clinical efficacy. The information contained in the clinical care review is expected to be incorporated into clinical decision making related to the ongoing need for care provided to the patient.

E. The treating provider for a patient has the ability to appeal a clinical care review decision.

1. A provider may initiate an appeal using the CCR Appeal Request Form after completing the Clinical Review Update note in the patient's record.

The note is to be used to submit additional information that may further support the medical necessity for ongoing care. At no time may the provider alter the existing medical record.

2. A clinical care reviewer who was not involved in the initial decision or the Clinical Review Manager will review the appeal and respond to the appeal within 7 calendar days.
3. Once an appeal decision has been reached and communicated to the provider, the decision is final and cannot be reversed.

F. Tracking of clinical care reviews

1. The Quality team will maintain a database of all completed reviews for a period of 2 years after the date of the most recent review.
2. The Quality team will conduct trend analysis of aggregate data and provider-level analysis for the purposes of quality improvement.
3. Aggregate data reporting on determination outcomes and provider-level results of providers treating patients with successive reviews will be regularly reviewed at Quality Assurance Process Improvement committee meetings to determine if additional actions are needed.

Attachments:

None

Was this article helpful?

Yes No

0 out of 0 found this helpful

Related articles

Risk Assessment and Safety Planning Policy

Appointment No-Shows and Late Cancellations Policy

Back to website

EXHIBIT C

Rula, Video of a Rula webinar published on Rula's YouTube station entitled "Kaiser Clinical Care Review Overview," January 17, 2024.

Available at https://www.youtube.com/watch?v=zstlMmdfX_8

NUHW downloaded a copy of this video from Rula's YouTube station and can provide it upon request.

EXHIBIT D

On Friday, January 19, 2024, 6:25 PM, quality@pathccm.com <quality@pathccm.com> wrote:

Hi [redacted]!

We wanted to follow up after our Kaiser Clinical Care Review webinar on January 17th, 2024 to share some information that we hope you'll find helpful.

During the session, we discussed:

- **The purpose and importance of clinical care reviews at Path**
- **How the CCR process supports therapists in delivering ongoing care**
- **The role of Clinical Care Reviewers in determining medical necessity**
- **Insights into the CCR process and answers to common questions**

You can watch the full recording of our initial session here and review in written format the answers to commonly asked questions here.
If you have any additional questions or feedback, please email us at quality@pathccm.com

As always, thank you for the work you do to support Path clients.

Wishing you a great start to the New Year,
Path Quality

EXHIBIT E

Demystifying the Clinical Care Review Process: *Q&A

(This list is inclusive of all questions over time from each monthly CCR session)

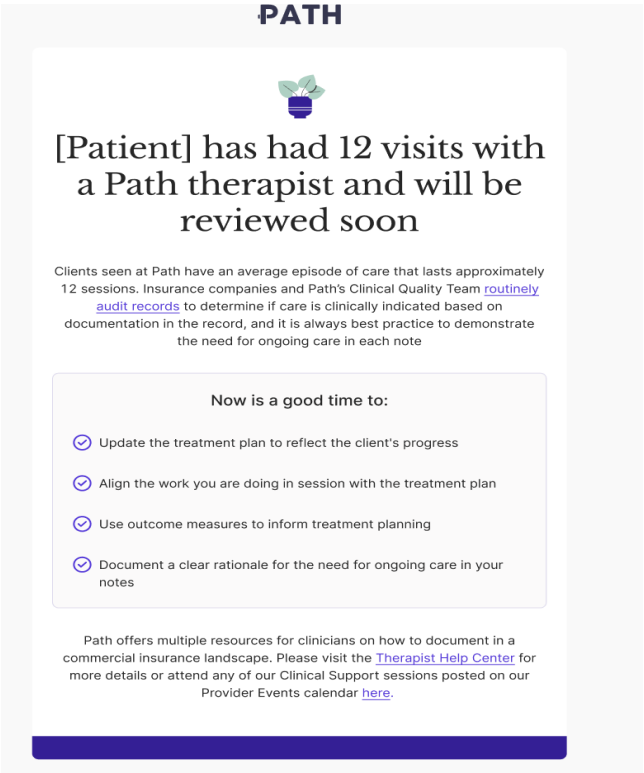
Q: Is a provider able to opt out of Kaiser clients from Path if FT for Kaiser?
A: No, providers cannot opt out of providing services to clients based on their insurance type, unless there is an identified conflict of interest.
The CCR process only requires a call to action if/when it's determined the need for on-going care is not present in a therapist's documentation. The easiest way to document medical necessity and ensure a smooth CCR process is for your documentation to reflect the client's need for ongoing care. This includes updating the client's treatment plan and fully detailing documentation of the client's current symptoms and the impact those symptoms have on the client's life (school, work, home, social/relationships) in your progress notes. Please reference the Sample Clinical Documentation Library (link here) for samples of clinical documentation you can use as a reference point to complete high-quality, compliant documentation in your own practice.

Q: I discharged a client with Kaiser insurance but they've recently reached out to me about returning to treatment. How can I coordinate this?
A: Have the client reach out to billing@pathccm.com to confirm if their Kaiser referral on file is still active to cover future sessions. If referral is active and they re-start sessions, their session count will resume and the chart will come up for review accordingly. For more information about when a chart is reviewed, reference the CCR article in the therapist help center, link here.

Q: Do all providers get reviewed?
A: No. Currently clinical care reviewers are only applicable to clients in CA with Kaiser coverage only therapists in CA who are credentialed with Kaiser are applicable for a CCR. Please see here for more information.

Q: How soon after a review should we expect to hear from someone?
A: Therapists are only notified about a completed review if the need for on-going care is not present in their documentation. Please see here for more information.

Q: Are we notified before a review occurs?
A: Yes. Path will send automated emails to therapists if their client is approaching their 12th session. This is the only other correspondence you will receive unless a review is completed and on-going care is not determined (see next question below). The subject line of these emails are currently shown as [Patient's] chart will be reviewed soon and appears as:



Q: Should I just assume a CCR already happened if I didn't get notified?
A: CCRs occur in the background of your practice. You will only hear from us and need to take action if we email you stating the need for on-going care was not present. Please see here for more information.

Q: Is it possible to have this training and other training to be recorded in the future?
A: A previous recording of the initial session which covered the same content/slides as today's current session can be found here. These sessions will reoccur monthly and will go over the same information.

Q: What is the frequency of updating the treatment plan?
A: At Path, there is no set required timeline for review and updates of treatment plans. However, you should update as often as clinically indicated to ensure the treatment plan reflects the presenting problem, current goals, and interventions to address the client's symptoms and treatment needs. Aside from guiding treatment, this is particularly important when considering the need for ongoing care and the medical necessity for services. Please see here for additional information.

Q: One client told me she wants to stop therapy next week. Is there a procedure for their last session? ***A: Please refer to Path's Patient Discharge Policy, link here. You can additionally view Path's best practices and information about discharge notes, here.***

Q: I received an email notification about a CCR but they've already been discharged from my care. Is this an error?
A: Yes. This is likely a system error. Please disregard emails for any clients that have been discharged and have not had any continued sessions.

Q: Where in the progress note would you indicate the rationale for continued care?
A: Depending which template you're using, it will likely get documented in the summary of the session or when you're documenting their presenting problem. For more information about quality progress notes, please see here.

Q: Will I also receive an email around the (additional) 10th session date/ for ongoing reviews?
A: No. Reviews are completed prior to the 16th visit (typically after the 13th session) and then every 10 visits after that while a client is engaged in care (i.e., session #13, 23, 33, 43, etc.). We will not send notifications after the 1st review unless the need for on-going care was not present. The easiest way to ensure a smooth CCR process is for your documentation to reflect the client's need for ongoing care. This includes updating the client's treatment plan goals & progress or lack of (if/as needed) and documenting in progress notes the client's current symptoms and the impact those symptoms have on the client's life (school, work, home, social/relationships). Remember: CCRs occur in the background of your practice so if you don't receive any emails after the 12th session, it's safe to assume that the client's chart was reviewed, the need for ongoing care was present during the time of review, and they were reauthorized for an additional 10 sessions.

Q: How is it looked upon if a diagnosis changes throughout therapy? Some clients, especially with regards to substance abuse, bounce back and forth with acceptance of the diagnosis.
A: Clients do not have to agree with their diagnosis. It's within your professional practice and scope to determine if a client meets criteria for a specific diagnosis. We understand that diagnoses may change throughout the course of treatment. When you are updating the client's diagnosis, please be sure to explain the symptoms the client is having and why the diagnosis was changed in your clinical documentation. Second, be sure the goals on the treatment plan are adjusted to align with the new diagnosis.

Q: Will a client not completing ongoing measures affect their number of sessions?
A: No. Check out this slide deck for more information about why we believe outcome measures are so valuable for clients and their providers.

Q: If/when I receive an email stating the need for ongoing care is not present in my client's chart and I'm recommending continued sessions, how long do I have to complete a clinical review update note and submit the clinical review form?
A: If you're recommending on-going care (even if for a few extra sessions to appropriately discharge), we recommend completing both steps in the email you received prior to your client's next appointment. You have up to 30 days to complete these steps, but we suggest doing this

sooner rather than later to avoid delays in your client's care. Please do not continue sessions until you've completed both steps and received an email confirmation from us.

Q: What's the limit for clients with severe axis II comorbidity and clients with chronic severe mental illness?
A: Further care is determined by your documentation of the client's symptoms and functional impairments.

Q: Can we refer a Kaiser client to a psychiatrist?
A: Please see here for more information regarding Kaiser clients & psychiatry referrals.

Q: Can we meet with a Path consultant for case consultation?
A: Yes! Our Clinical Quality Coaches (CQCs) offer Clinical Support Office Hours several times per week in addition to facilitating a Case Consultation group. All of these events can be found on the Therapist Events Calendar. For more information regarding our CQCs, please visit the help center article, here. You can also join the #case-consultation channel located in Path's Therapist Network Slack.

Q: Does a Kaiser client also have a voice in asking for continued care as needed?
A: Absolutely. And we rely on you as their therapist to vocalize this for them in your clinical documentation. For more information, please see the help center article, here.

Q: Does a Kaiser client need to request couples or family counseling?
A: There is no need for a client to request another authorization for couples counseling from Kaiser. They can reach out to Path's support team to get set up with those specific services.

Q: Where can I look for/reference to help me with documentation?
A: Please utilize our help center article, Sample Clinical Documentation Library. You can use this as a reference point to complete high-quality, compliant documentation in your own practice.

Non-CCR related

Q:If you do any collaterals (e.g. release to talk to a teacher for kids), are you allowed to bill for that?
A: Collaterals are non-billable. Please see the Therapist Help Center Article for covered CPT codes, link here.

Q: Had a client that came for an intake and during the 2nd partial session, they said they were not sure….(lost connection/sound?)
A: Please see the Therapist Help Center article, link here.

Q: Are all insurance companies looking at progress notes?

A: Most insurance companies have a way of ensuring medical necessity is present within a provider's documentation.

EXHIBIT F

Click here if you received an email indicating that a client's episode of care is almost complete.

What is Clinical Care Review?

A Clinical Care Review (CCR) is a qualitative and quantitative review of documentation in a client's record to determine if there is a clinical need for ongoing care. You can read our CCR policy here.

Who completes the Clinical Care Review?

Rula employs licensed Clinical Care Reviewers who are members of the Quality Team. Each reviewer has more than 5 years of clinical experience and has spent a minimum of 3 years engaged in peer review or utilization management.

Which clients receive a Clinical Care Review?

At present, the CCR process is only in place for clients covered by Kaiser SoCal.

When does a Clinical Care Review take place?

Reviews are completed prior to the 16th visit (typically after the 13th session) and then every 10 visits after that while a client is engaged in care (i.e., session #13, 23, 33, 43, etc.).

Do I need to keep track of session counts?

No. The Clinical Care Review takes place automatically in the background of your practice. There is no need for therapists to count sessions or reach out to Rula to request a review. There is no need for the client to count sessions or reach out to Kaiser to request additional care.

Do clients have a limit to the number of sessions they can have through Rula?

No. Kaiser provides an initial outpatient therapy referral from the client's PCP for up to 16 sessions. This is a very misleading referral for clients and therapists, as there is often a misperception that the client is limited to 16 sessions, which is incorrect! **Clients may continue to receive care as long as documentation reflects a clinical need for treatment.**

What documentation is reviewed to determine the need for ongoing care?

Support for clinically indicated care is present when the following is reflected in clinical documentation:

- The service is directed towards reducing the effect of symptoms/behaviors of the diagnosis on record and its resulting functional impairments (i.e., explain how symptoms/behaviors are impairing the person's life) or,
- The service is provided to prevent an increase in symptoms/behaviors or functional impairments (i.e., explain how services are provided to prevent deterioration or to maintain the current level of functioning)

The reviewer is evaluating the following aspects:

- DSM diagnosis with clearly documented symptoms
- Moderate to severe symptom severity and the presence of associated functional impairments (i.e., symptom distress interferes with work, school, relationships or social functioning)
- Interventions are targeted to impact functional impairments, align with the current treatment plan, and are reflected in progress notes (i.e., the presence of the Golden Loop!)
- Goals on the treatment plan are actively updated, being worked on; align with the diagnosis and progress notes
- Outcome measure changes that indicate a need for ongoing care
- Client is engaged in care as evidenced by regular attendance in appointments and completing therapeutic tasks
- Client is capable of developing skills to manage symptoms or make behavioral change
- Client does not require a higher level of care (HLOC)

> Note: If you're not already discussing the outcome measures with your clients, we strongly recommend you introduce that into the relationship and to guide treatment planning. Details about the use of outcome measures in practice can be found here or on the Therapist Help Center (password is Path1234).

How will I know if ongoing care has been deemed clinically indicated based on my documentation?

Your clinical work drives this decision based on what is documented in the client's record. If you don't hear from Rula, continue to treat your client as needed. The Clinical Care Review process will repeat itself continuously in the background of your practice, and will rely on your notes regarding the client's needs and the treatment plan (as described above). No action is needed.

If ongoing care is not clinically indicated:

- You will be notified via email of this determination.
- You are expected to discuss discharge from care with your client.
- The email notification will include aftercare resources to review with your client.

Here are some of Rula's reasons for determining clinical justification is not present:

- Documentation reflects that the client has or is approaching achievement of their goals
- The client requires a higher level of care
- The purpose of care is not directly related to improving symptoms and/or functional impairment specified on the treatment plan

What if I disagree with the Clinical Care Review and believe my client needs more care?

Your clinical work drives this decision based on what is documented in the client's record. In most cases, a CCR will assess that care is not clinically indicated based on a lack of documentation of medical necessity in the record (see above).

If you disagree with the Clinical Care Review decision, you may complete the clinical review update (note & form) the decision by taking the following steps:

1. Complete a Clinical Review Update note in the client's record. See examples here. **This non-billable note is only to be used if you receive an email notification of a CCR decision you believe was made in error. The client does not need to be present in order to complete the update note.**
2. Complete and submit the Clinical Review Update form provided in the email notification. You must enter the date you received the email notification in order to submit the Clinical Review Update form.
3. A Clinical Care Reviewer will respond to your Clinical Care Review Update submission within 7 calendar days.

What if I recommend discharge for my client but need a couple or more sessions to coordinate termination?

If you believe the client needs continued sessions (even if it's just a couple of sessions to appropriately discharge), please complete an additional Clinical Review Update note that indicates the client's symptoms (even if minimal), and the impact on their functioning. This will enable our team's understanding of the client's current situation; that of which necessitates continued care and discharge planning.

How long do I have to complete the CCR Update process?

Rula therapists are typically given 30 days to complete a Clinical Review Update Note & submit the form for any clinical care review determining additional clinical justification is needed. This is to ensure/prevent the Kaiser referral from expiring in the event you feel the need to provide a clinical review update note.

Kaiser will not pay for care that has been determined to be not clinically indicated based on the Clinical Care Review and Rula may not reimburse providers who continue to provide services following a determination that the episode of care is not clinically indicated.

Rula will assign you new clients to fill your caseload as clients complete care if your calendar has slots available for new clients and you have not paused yourself.

Questions about the process?

Contact the Rula Clinical Quality Team at quality@rula.com

EXHIBIT G

Measuring Client Outcomes: Path Provider FAQ

What measures are being collected?
The **baseline check-in survey** includes symptom screeners: the GAD-2 for anxiety and the PHQ-2 for depression, as well as the 1st question on the AUDIT-C to capture alcohol use.

If a client answers positively on a screener, the rest of the measure is asked (i.e., the GAD-7, the PHQ-9 and the 2nd and 3rd question on the AUDIT-C). If a person scores positively on the last question of the PHQ-9, the client will complete the Columbia Suicide Severity Screening Scale. This process is called "*response logic*" and allows for clients to skip items that are not pertinent to them at that time.

For **ongoing check-in** surveys after treatment has begun, the client will be asked all of the baseline items plus two questions about the Therapeutic Alliance.

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.
2. I feel that my therapist understands me.

This group of measures is called a "measurement bundle."

How long does the survey take?
Each check in survey takes no more than 5 minutes to complete. The length of time depends on the response logic built into the screeners. There are between 7-27 questions in the measurement bundle.

Why are we doing this?
Check out this slide deck for more information about why we believe outcome measures are so valuable for clients, providers, our payers, and the public You'll find a 4 minute video demo of the surveys on slide 8 (video here).

How is the survey link sent to clients?

- An email with a link to a baseline "check in" survey is sent to clients 2 days prior to their first appointment or any 90791 appointment. Each time a client starts with a new provider we reset the measures to capture their baseline.
- Path sends an automated email requesting clients to complete a check-in survey 2 days before every appointment.
- All check-in links are sent to the email address on file in AdvancedMD and where appointment links are sent. Please ask your client to check their spam folder if they are not seeing this communication.

What messages are you sending to my clients about this?

- We are messaging to all clients that measurement is a routine part of care and is expected to be completed.
- The name of the client's provider is included in the email message, which reads:
  "Your provider, Sandra Liu, would like you to complete this questionnaire before your first appointment to better understand how you're feeling at the start of treatment."
- We inform clients this information will be visible by their provider and that the check-in

typically takes less than 5 minutes to complete.

Is this mandatory?
We expect all clients to complete these regular check-in surveys as a standard of care with Path. However, not completing the survey does not stop treatment.

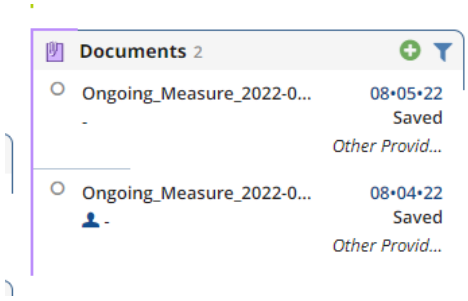
Is it possible for clients to opt-out?
Technically, yes, a client can click “UNSUBSCRIBE” on the emails. This is discouraged as surveys are considered to be part of the standard of care and may be required by some payors.

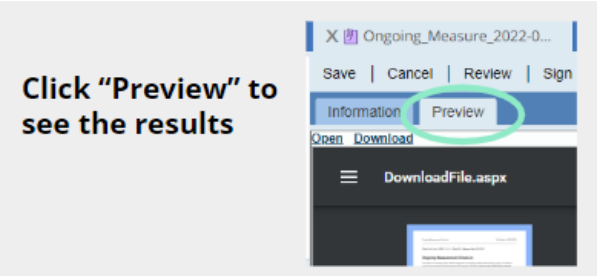
Do I have to do anything?
Nope! Path does all of the data collection for you and makes it easy to see results. All we ask is that you encourage your clients to complete these surveys and then discuss them in treatment. No specific action is dictated by Path.

Can I have the client complete their survey in session?

- To ensure these check-ins are not specific to any one session, we want clients to complete these on their own based on how they have been doing over the past 2 weeks (or month depending on the item). Please encourage or remind your clients to complete the check-in prior to their sessions.
- If the client has not completed their survey, feel free to ask them to click on the link in their email to complete it during the session. The results should be visible in AMD within 5 minutes.
- We anticipate there will be an option for the provider to complete measures live with the client in session in the future, but that feature is not available at this time.

Where do I find my client’s results?
You can find a PDF of each client’s result in the Documents folder of the client’s chart in the EHR.





The first survey is titled “Baseline” and future surveys are labeled “Ongoing”. We encourage you to check the baseline and the most recent ongoing survey to compare results.

How are the results calculated?

- You’ll see scoring for each individual measure with a point value. For example, the PHQ-9 has a total possible score of 9. Lower scores indicate lower symptoms and a stronger therapeutic alliance.
- You’ll also see a total score of all measures. There are a total of 72 points possible. Lower scores indicate lower symptoms and a stronger therapeutic alliance.
    - All providers are assigned a 0 score (the highest possible value) for the

therapeutic alliance questions during the baseline survey since the client hasn't met you yet.

How should I use the results with my client?
We encourage you to review the results in session with your client as a way to partner on their therapeutic journey. The more interest you show in the results, the more the client will engage.

There are many ways to engage clients in **measurement based care**. Measurement based care (MBC) is the regular numerical assessment of symptoms that tracks client response to treatment over time. Ample research evidence confirms that measurement based care improves client outcomes.

We have a step by step guide on MBC that offers quite a bit of information on how important this is to our profession and to helping clients get better faster. Click here to view the video.
**Note: CEUs will be available for this training in the future. Please email quality@pathccm.com if you watch the video. We will contact you when CEUs are available.*

MBC allows the provider to partner with the client to answer the following questions:
1. Are we working on the right goals?
2. Are we doing the right things in treatment to get us there?
3. Do we have trust and respect for one another in our therapeutic relationship?

Some suggestions from Path providers for how you may want to use measures in practice include:
- Let the client know that their results are confidential and for you and the client to review
- Talk about measures at the start of treatment to help clients understand what to expect as part of the treatment process
- Frame the value and importance of measures as an important part of the therapeutic process
- Review results to open dialogue with a new client
- Highlight symptoms self-reported by the client as a way to frame the focus of the session
- Incorporate conversations about why a score went up or down– talk about improvements, stagnation, deterioration, or fluctuations over time
- Encourage clients to use the measures as a different way to communicate with you
- Provide consistency for clients who benefit from tangible tracking of their progress
- Talk about a client's responses to the therapeutic alliance questions to see how you can make sure the client is getting what they need from the partnership
- Use results as a guide for clients who don't know exactly what they want to work on in session.
- Use individual responses on measures to help clients recognize symptoms they may not have been aware of or to articulate an area that needs attention
- Let the client know that consistent measures over time allows you to hold yourself accountable to know if the work you are doing is helping

What if there are no results in the Documents folder for my client?
If you don't see survey results in the Documents folder, please check in with your client to see if they received the email from Path. If they did, please ask them to complete it. You can also have them complete the survey in session by clicking on the link in their email.

How do I encourage clients who are not motivated to complete the survey?
1. **Provide a rationale:** Understanding the why can really motivate people. (Why should I

do this? Why should I care?) A quick conversation might work for some clients, whereas others want to conduct their own research.
2. **Build accountability:** Try creating more accountability in sessions to follow the expectations of participating in therapy. You may want to assign measurement completion as homework to review in a future session.
3. **Ask for the client to identify expectations for change:** A tangible measure is a good way to involve the client in goal setting and investing in their own progress. Have the client specify an area they want to improve.
4. **Focus on how measures help your partnership:** Reviewing results is an excellent way for the therapist and client to talk about what's working well and what may need to change. *"I want to be sure you get what you need from me to get better and that the work I'm doing makes a difference for you. These surveys are one way for us to do that."*
5. **Ease concerns about privacy:** Explain who will see the results. Let the client know the results are confidential and not being shared directly with their insurance or anyone else.

Do kids take these surveys?
Clients aged 13 and up who are receiving treatment through a Path provider complete the same surveys. The measurement items we selected are appropriate for adolescents and adults.

We recommend that you review results with the child's parent or guardian to involve them in treatment (when clinically appropriate) and to obtain their input on the measures. It's possible that an adolescent may rate their symptoms differently than a parent, which is a great topic to discuss in session.

We do not yet collect outcome measures for children ages 5-12.

How are measures used with couples and families in treatment?
The primary client will complete the check in surveys and will answer questions about themselves. Since there is always a primary client in couples and family treatment, we are tracking the progress of this person.

Is the check-in survey available in other languages?
Not at this time. The client may contact Support to arrange for an interpreter as needed.

Who sees the individual results?
- You (the client's provider)
- The Path Quality team
- It is possible that payors will have visibility of individual client results as part of a clinical review process in the future, but that is not in place at this time.

How is Path using this data?
Having data on client outcomes allows Path to better tell the story of the impact of the work being done. We believe sharing aggregate, de-identified information publicly may help decrease the stigma associated with mental health treatment and will elevate the mental health profession.

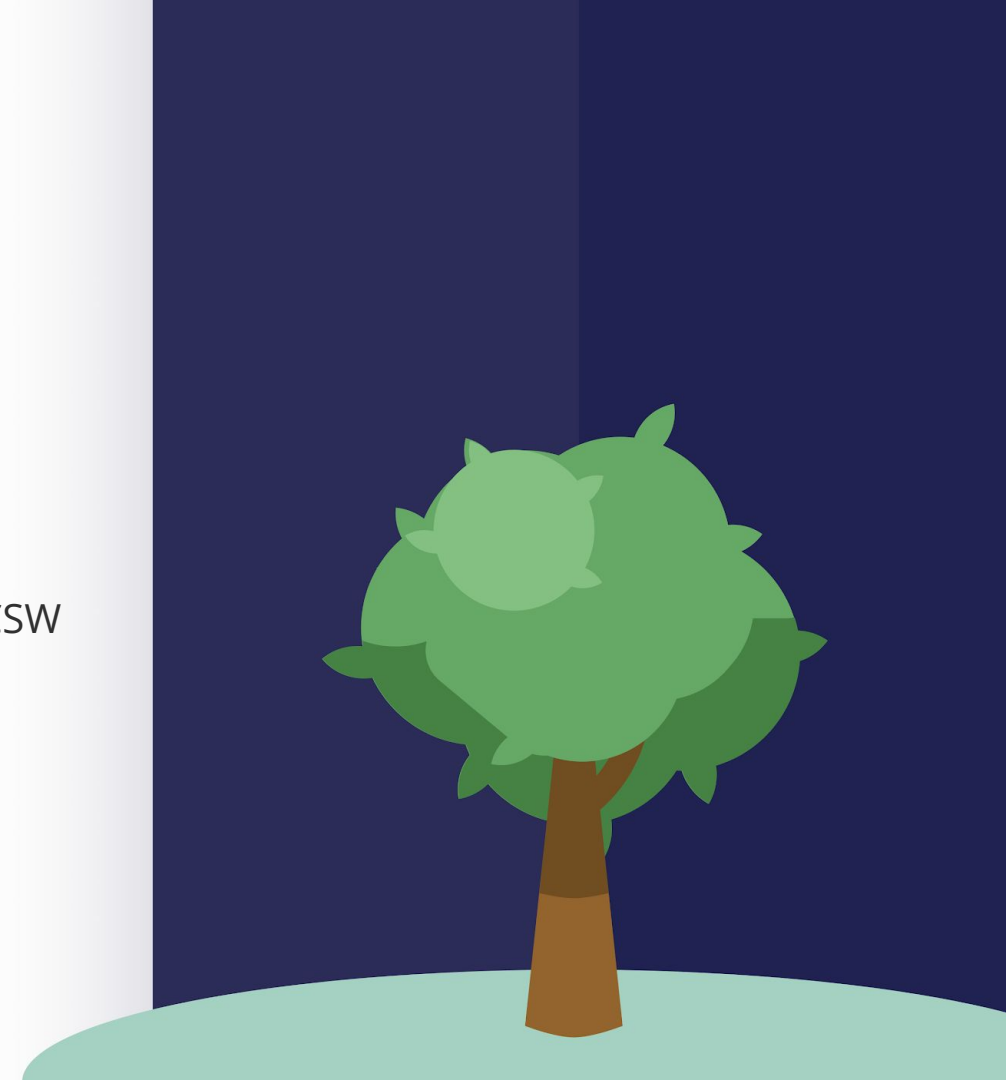
Path analyzes anonymous aggregate trends to evaluate the outcomes of treatment. We will share aggregate data with commercial insurance plans to negotiate rates and offer transparency of the work that's being done. We will also talk about aggregate data in our conversations with referral partnerships to help increase the number of clients referred to Path and thus, as a way to get you more clients.

EXHIBIT H

PATH

Measuring Client Outcomes

Prepared by Cynthia Grant, PhD, MBA, LCSW
Path Head of Clinical Care



Proprietary and Confidential: DO NOT DISTRIBUTE

What we believe

about the use of outcome measures

01

Clients

Clients and providers have a **tangible measure** of progress

Reviewing results allows providers and clients to **partner in the treatment process**

Gives the **provider feedback** on what's working

02

Providers

Helps us be better providers

Elevates the mental health profession

Offers insight into client symptoms with **no burden on providers** to collect

03

Payers

Outcome data can be used to negotiate **increased rates** with payers

Will soon be a payer **requirement**

Will lead to **more referrals** from payers & partners

04

Other

Showing positive results of therapy can help **decrease stigma**

Should be part of the **standard of care** received at Path

Sharing aggregate results may lead **more clients** to choose Path

PATH

An improvement in our practice

What we do now

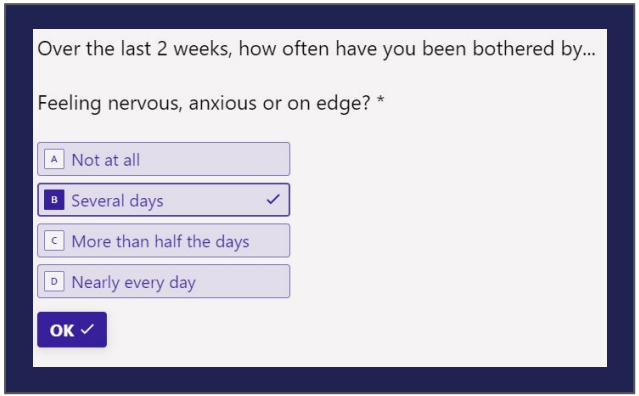
- Distribute a GAD-7 and PHQ-8 survey once a month to all active clients
- Email is distributed by Path and is voluntary
- No provider visibility of results
- Response rate ~10%

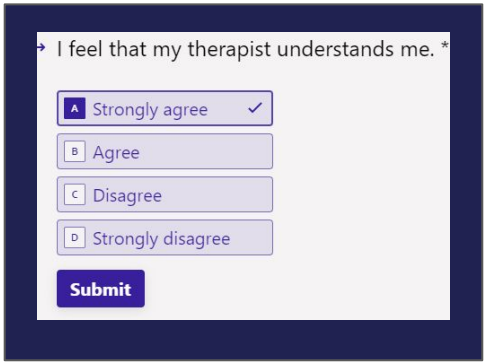
What's changing

- Distribute a "measurement bundle" to all active clients:
  - Prior to the first appointment (baseline) *and*
  - Every week the client is engaged in care (ongoing)
- Email will include the provider's name. It is expected that all clients will complete the measures as part of their care at Path
- Providers will be able to see results in AMD

How we selected the measurement bundle

- Brief (less than 5 minutes to complete)
- Reliable and valid
- Self-administered
- Easy to complete (mobile or desktop)
- Easy to understand
- Clinically relevant to decision making
- Score is sensitive to change
- Commonly understood/accepted by payers and partners





Baseline measure

Sent 2 days prior to first session

1. A set of screening tools to capture symptoms of anxiety, depression, & alcohol use

   GAD-2, PHQ-2, AUDIT-C (1st question)

2. If a client answers positively to any items on the screener, the full tool will display

   GAD-7, PHQ-9, AUDIT-C (2nd and 3rd questions)

3. A positive response to the last item on the PHQ-9 will result in a suicide screener to display

   Columbia Suicide Severity Rating Scale

Ongoing measures

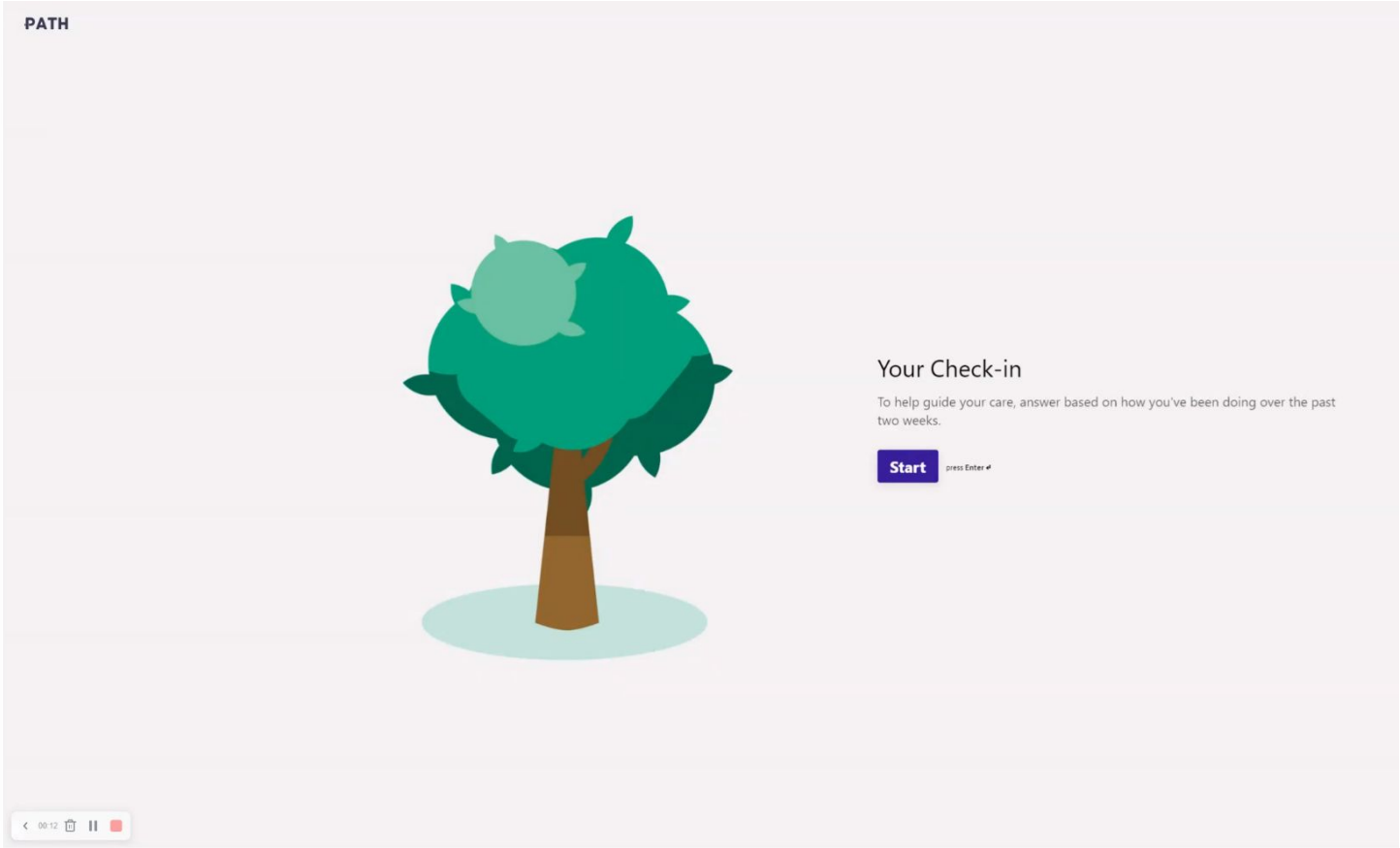
Sent 2 days before their next appointment each week

Therapeutic Alliance items

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

2. I feel that my therapist understands me.

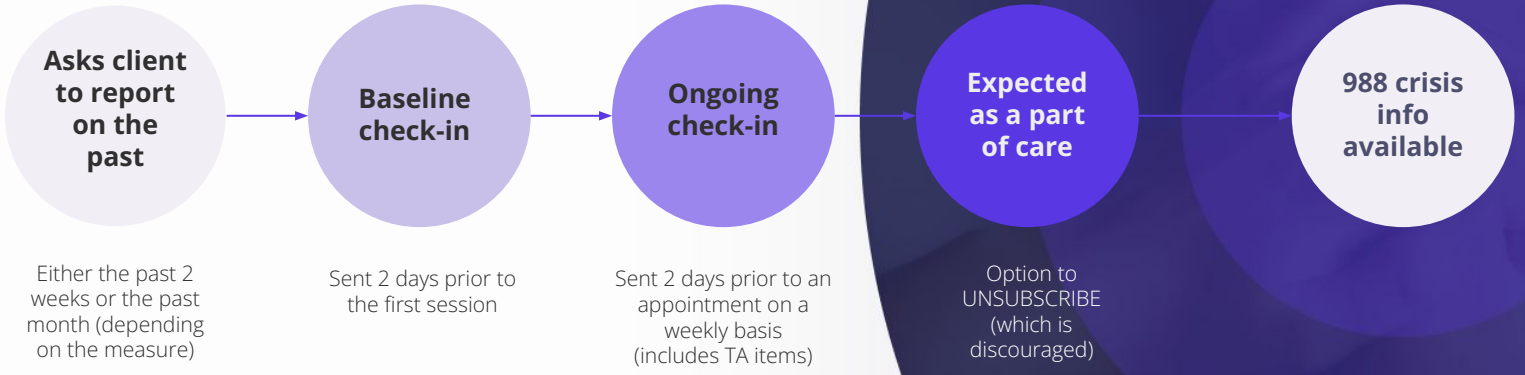
Note:
The frequency of measurement distribution was changed to weekly (2 days prior to an appointment) on **11/4/22**



Click the weblink in the text to watch a 4 min video of the survey→

Check in Survey for Path

How data collection will work for clients



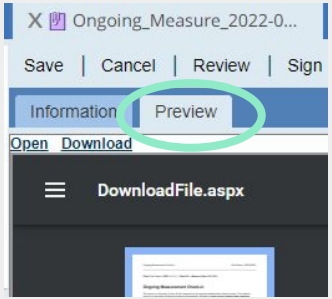
Where providers can find client results

Automatically displays in the client's chart in AdvancedMD as a PDF titled:

- Baseline Measure (date)
- Ongoing Measure (date)

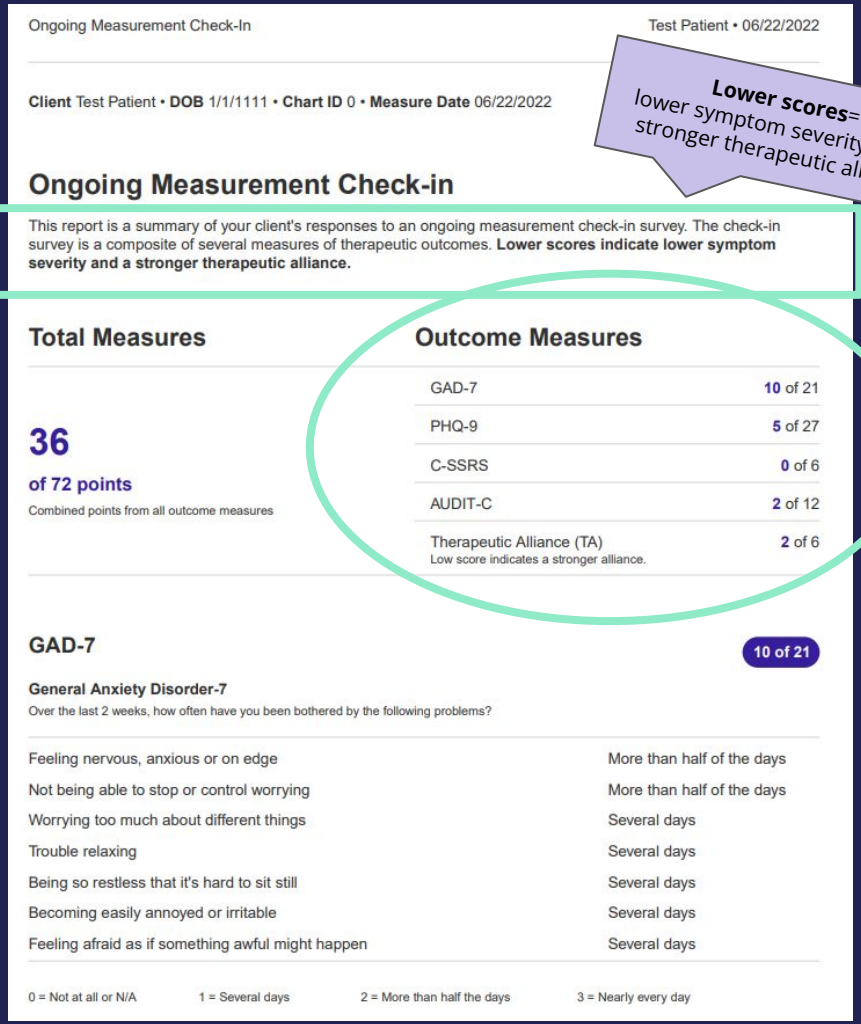
Documents folder

Click "Preview" to see the results



How to interpret the score

- View individual measure results
- Meaningful clinically indicated differences (MCID) are:
  - GAD-7: 4 point reduction
  - PHQ-9: 50% point reduction
  - AUDIT-C:
  - C-SSRS: Reduction from 3+ to 0-2



Ongoing Measurement Check-In

Test Patient • 06/22/2022

Client Test Patient • **DOB** 1/1/1111 • **Chart ID** 0 • **Measure Date** 06/22/2022

Lower scores= lower symptom severity and a stronger therapeutic alliance

Ongoing Measurement Check-in

This report is a summary of your client's responses to an ongoing measurement check-in survey. The check-in survey is a composite of several measures of therapeutic outcomes. **Lower scores indicate lower symptom severity and a stronger therapeutic alliance.**

Total Measures

36

of 72 points

Combined points from all outcome measures

Outcome Measures

GAD-7	**10** of 21
PHQ-9	**5** of 27
C-SSRS	**0** of 6
AUDIT-C	**2** of 12
Therapeutic Alliance (TA) Low score indicates a stronger alliance.	**2** of 6

GAD-7

10 of 21

General Anxiety Disorder-7

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge	More than half of the days
Not being able to stop or control worrying	More than half of the days
Worrying too much about different things	Several days
Trouble relaxing	Several days
Being so restless that it's hard to sit still	Several days
Becoming easily annoyed or irritable	Several days
Feeling afraid as if something awful might happen	Several days

0 = Not at all or N/A 1 = Several days 2 = More than half the days 3 = Nearly every day

PATH

Our ask for providers

1. Encourage your clients to complete their survey each time they get an email
2. View your client's results. Talk to them about their results if it fits with your practice.
3. Share your feedback!
quality@pathccm.com