DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

COMMUNITY CARE HEALTH PLAN, INC.

AUGUST 31, 2023

Behavioral Health Investigation
Community Care Health Plan, Inc.
August 31, 2023

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department received approval from the 2020-21 state budget to conduct focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California laws and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of Community Care Health Plan, Inc. (Plan) is included in Phase One.

On April 16, 2021, the Department notified the Plan of its BHI covering the time period of April 1, 2019, through March 31, 2021. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2]

The investigation team interviewed the Plan and its pharmacy benefit manager MedImpact Healthcare Systems, Inc. (MedImpact), on March 3, 2022. Santé Community Physicians IPA Medical Corporation (Santé), the Plan's behavioral health delegate during the BHI review period, did not attend the March 3, 2022 interviews as the Plan's contract with Santé terminated effective December 31, 2021.

Although Santé did not participate in interviews, the Plan provided and the Department reviewed documents Santé provided to the Plan pertaining to delegated services, including utilization management, credentialing, claims payment and provider dispute handling policies and documents. Additionally, the Department reviewed Santé's performance and case files for utilization management and claims.

The BHI uncovered ten Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, Pharmacy, Quality Assurance, Grievances and Appeals, and Cultural Competency, Health Equity and Language Assistance:

1. The Plan failed to demonstrate it has a process for determining geographic accessibility and timely access for medically necessary pervasive developmental disorder and autism health care services.

[1] The Knox-Keene Health Care Service Plan Act of 1975 is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

[2] For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

2. The Plan failed to consistently notify requesting providers of authorization decisions within 24 hours of making the decision.
3. The Plan's behavioral health delegate failed to demonstrate its pharmacy benefit manager has policies and procedures for formulary exception requests as required by state and federal laws, or that such policies and procedures were filed with the Department.
4. The Plan is operating at variance with its Evidence of Coverage filed with the Department.
5. The Plan failed to perform oversight of its behavioral health delegate to ensure the enrollees' ability to obtain timely, medically necessary behavioral health services.
6. The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing its delegate to perform quality assurance functions.
7. The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing the delegate to resolve grievances.
8. The Plan failed to ensure customer service staff are knowledgeable and competent regarding enrollee questions and concerns.
9. The Plan does not consistently identify grievance categories as required.
10. The Plan failed to provide adequate training to Plan staff concerning the Plan's language assistance program with respect to understanding the cultural diversity of the Plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Additionally, the Department identified four barriers to care not based on Knox-Keene Act requirements in the areas of Utilization Management, Pharmacy, Cultural Competency, Health Equity and Language Assistance, and Enrollee and Provider Experience:

1. The Plan conducts utilization review for behavioral health services that do not require prior authorization.
2. The Plan does not have a policy to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy.
3. The Plan has not developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location.
4. Neither the Plan nor its Delegate have customer service center policies and procedures to ensure proficient, effective, and appropriate customer service for enrollees.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. In this case, the investigation identified no Plan initiatives or operations that result in positive impacts on the Plan's provision of and/or enrollee access to behavioral health services.

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

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[3] Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.[4]

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analyses of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine surveys review for compliance and the enforcement of requirements of SB 855

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

(Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[5] To evaluate the Plan's operations for the review period of April 1, 2019, through March 31, 2021, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and Pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

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

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

[5] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or any other non-Department regulated product.

PLAN BACKGROUND

The Plan was licensed in 2013 and operates as a for-profit organization, wholly owned by Fresno Community Hospital and Medical Center dba Community Hospitals of Central California, a nonprofit public benefit corporation headquartered in Fresno, California. The Plan services Fresno, Kings and Madera counties with a total enrollment of 11,765 commercial enrollees.[6]

For pharmacy benefits, the Plan utilizes pharmacy benefit manager MedImpact. For certain administrative services, the Plan has a management services agreement with Santé Health System, Inc. (SHS) pursuant to which SHS agreed to perform administrative services for the Plan. This agreement was amended effective January 1, 2017, and was in effect at all times relevant to this BHI. Under the terms of the amendment, services to be provided by SHS were identified as call center services including documentation of calls and reporting to the Plan; financial services including claims administration; development of a management information system to include patient tracking, claims processing, utilization analysis and eligibility determination; and all duties relevant to patient eligibility.

The Plan entered into a separate medical group provider agreement with Santé Community Physicians IPA Medical Corporation (Santé), an affiliate of SHS. Under the medical group provider agreement, the Plan delegated provision of behavioral health services to Santé. During the review period, Santé performed utilization management, credentialing, claims payment and provider dispute functions on behalf of the Plan. Santé also provided a network of providers, including behavioral health professionals, which were contracted through Bio Behavioral Medical Clinics (BBMC). Santé subdelegated utilization management functions for behavioral health services to BBMC.

The Plan's contract with Santé terminated effective December 31, 2021. Effective January 1, 2022, the Plan delegated to Halcyon Behavioral, LLC dba Halcyon Administrators (Halcyon), claims adjudication and provider dispute resolution, utilization management functions, credentialing and customer service and case management.[7] The Department will conduct a second phase BHI of the Plan to investigate Halcyon's delegated behavioral health operations, including but not limited to use of utilization management criteria required by Section 1374.721. A BHI Report addressing this second phase BHI will be subsequently published.

[6] Enrollment data reported by the Plan as of March 31, 2021.

[7] The Plan's management services agreement with SHS also terminated December 31, 2021. Effective January 1, 2022, the Plan entered an administrative services agreement with HealthComp Holding Company, LLC and its subsidiary HealthComp LLC to perform the administrative services previously performed by SHS.

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan failed to demonstrate it has a process for determining geographic accessibility and timely access for medically necessary pervasive developmental disorder and autism health care services.

Statutory/Regulatory Reference(s): Rule 1300.74.73(a)(3)(C)

Supporting Documentation:

- *Community Care Health Plan Timely Access Policy and Procedures* (August 8, 2019)
- *Standards of Accessibility* (August 8, 2019)
- Plan document listing Autism Facilities for Measurement Years 2019 and 2020. My2019_My2020
- PAAS Survey Results Measurement Year 2019
- PAAS Survey Results Measurement Year 2020

Assessment: Rule 1300.74.73(a)(3) states:

> Each health plan that is subject to the requirements of section 1374.73 of the Act shall submit a report to the Department no later than December 31, 2012, demonstrating that the health plan has an adequate network of qualified autism service providers, qualified autism service professionals and/or qualified autism service paraprofessionals. The required report shall include the following information:
>
> A description of how the health plan is determining provider network adequacy, including how geographic accessibility and timely access for health plan enrollees to medically necessary PDD[8] and autism health care services is being met. This information should include: 1. Data describing the adequacy of the health plan's provider network for each region or service area, including utilization data and information on the health plan's enrollee population, such as age, gender and other relevant factors used by the health plan; and 2. A description of the health plan's system for monitoring and evaluating provider network adequacy in each region or service area.

The Department requested the Plan provide, with respect to Pervasive Development Disorder and autism health care services, "…documents that include a description of how the Plan determines provider network adequacy, including how geographic accessibility and timely access are being met." The Department requested the Plan include a report on its current network adequacy for these services.

[8] Pervasive developmental disorder.

The Plan did not provide any responsive evaluations or reports. Rather, the Plan submitted a spreadsheet listing the name and contact information for its qualified in-network autism facilities for 2019 and 2020. The spreadsheets showed the Plan contracted with five facilities for 2019 and four facilities for 2020. The Plan also provided its *Community Care Health Plan Timely Access Policy and Procedures*. This policy spoke in general terms to accessibility standards for medical surgical and behavioral health services, but did not specifically address network adequacy or accessibility for pervasive developmental disorder or autism services. Neither document submitted by the Plan demonstrated the Plan has a process compliant with Rule 1300.74.73(a)(3).

During interviews, the Plan was asked if it evaluates and tracks its network adequacy for pervasive developmental disorder and autism services. The Plan responded that its new behavioral health delegate, Halcyon, provides those metrics.[9] There was no indication that responsive metrics were provided by Santé for the review period.

Accordingly, the Department finds the Plan out of compliance with these regulatory requirements.

Conclusion: The Plan did not demonstrate that it monitors and evaluates the adequacy of its network to meet the needs of enrollees with Pervasive Developmental Disorder and autism. Based on review of Plan documentation, the Department found the Plan in violation of 1300.74.73(a)(3)(C).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#2: The Plan's behavioral health delegate failed to consistently notify requesting providers of authorization decisions within 24 hours of making the decision.

Statutory/Regulatory Reference(s): Section 1367.01(h)(3)

Supporting Documentation:

- 65 Utilization Management authorization files (April 1, 2019 – March 31, 2021)

Assessment: Based on review of Santé utilization management authorization files, the Department found the Plan's behavioral health delegate was not consistently notifying requesting providers of the Plan's decision within 24 hours. Section 1367.01(h)(3) states, in part:

> Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision.

Section 1367(j) states, in relevant part: "The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting

[9] Santé, not Halcyon, was the Plan's contracted delegate during the BHI review period.

entities." Therefore, although the Plan delegated utilization management to Santé, the Plan retains responsibility for compliance with Knox-Keene Act requirements.

The Department reviewed a random sample of 65 standard utilization management authorization files from a universe of 784 files for the investigation period. The Department found that 31 files[10] (48%) failed to include documentation sufficient to demonstrate the Plan or Santé notified the requesting provider within 24 hours of making the authorization decision.

TABLE # 1
Timeliness of Notification of Utilization Management Decisions

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Utilization Management Authorization Files	65	Notification of approval determination to the provider within 24 hours of the decision	34 (52%)	31 (48%)

Conclusion: Section 1367.01(h)(3) requires the Plan or its delegate to notify requesting providers of utilization management authorization decisions within 24 hours of the decision. Based on review of utilization management authorization files, the Department found Santé files failed to consistently include documentation of the date and time it notified providers of utilization management decisions. Accordingly, the Plan and its delegate are unable to demonstrate compliance with Section 1367.01(h)(3).

PHARMACY

#3: The Plan failed to demonstrate its pharmacy benefit manager has policies and procedures for formulary exception requests as required by state and federal laws, or that such policies and procedures were filed with the Department.

Statutory/Regulatory Reference(s): Sections 1367.24 (a)(d) and (k); 45 C.F.R. 156.122(c)

Supporting Documentation:

- MedImpact *Appeals Policy Document # 410-PL-1016*, versions 10, 11, 12 and 13
- *Community Care Health Plan Combined Evidence of Coverage and Disclosure Form (HMO)* (January 1, 2021)

Assessment: Section 1367.24(a) requires every health care service plan that provides prescription drug benefits to maintain an expeditious process by which prescribing

[10] Utilization Management File #s: 2, 3, 5, 6, 7, 8, 12, 13, 24, 25, 27, 31, 34, 36, 38, 39, 41, 43, 46, 52, 54, 55, 56, 57, 58, 61, 62, 63, 64, 65, 67.

providers may obtain authorization for a medically necessary nonformulary prescription drug and to file a description of its process with the Department.

Section 1367.24(d) requires evidence of coverage and disclosure forms to include "the process by which enrollees may obtain medically necessary nonformulary drugs including specified timelines for responding to prescribing provider authorization requests."

Section 1367.24(k) provides that for any individual, small group, or large health plan contracts, a plan's process for authorization of medically necessary nonformulary prescription drugs must comply with the request for exception and external exception request review processes described in federal law.[11]

The applicable federal law requires plans to have processes in place to allow enrollees or their prescriber to "request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception)."[12] Plans must have processes in place to receive and timely respond to standard requests for exception and expedited requests for exception.[13] For standard requests, plans must make a determination and notify the enrollee of the decision no later than 72 hours from receipt of the request.[14] For expedited requests, plans must make a determination and notify the enrollee of the decision no later than 24 hours from receipt of the request.[15] If a plan grants an external exception review, the plan must cover the nonformulary drug for the duration of the prescription (for a standard exception request), or for the duration of the exigency (for an expedited exception request).[16]

In response to a request for policies and procedures pertaining to the Plan's pharmacy exception request process, the Plan provided its pharmacy benefit manager's *Appeals Policy.* The *Appeals Policy* does not include any description of an exception request process or response timeframes.

Finally, there is no indication the Plan filed an exception request policy and procedure with the Department as required by Section 1367.24(a).

Conclusion: Neither the Plan nor its pharmacy benefit manager provided evidence of documented, filed processes or procedures pertaining to an exception request to permit enrollees and providers to request and gain access to clinically appropriate nonformulary prescription drugs. The Plan provided no evidence of coverage documents for the portion of the review period prior to January 1, 2021, and the 2021 evidence of coverage document failed to describe the process by which an enrollee or

[11] 45 C.F.R. 156.122(c)(1)-(3).
[12] 45 C.F.R. 156.122(c).
[13] See 45 C.F.R. 156.122 (c)(1)-(2) (Expedited review of requests is required in exigent circumstances which exist when "an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.")
[14] 45 C.F.R. 156.122(c)(1)(ii).
[15] 45 C.F.R. 156.122(c)(2)(iii).
[16] 45 C.F.R. 156.122(c)(3)(iii).

authorized representative may obtain medically necessary nonformulary drugs. Accordingly, the Department finds the Plan out of compliance with Sections1367.24 (a), (d) and (k).

QUALITY ASSURANCE

#4: The Plan's behavioral health delegate was operating at variance with its Evidence of Coverage filed with the Department.

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

Supporting Documentation:

- *Community Care Health Plan Combined Evidence of Coverage and Disclosure Form* (HMO) January 1, 2021
- *Community Care Health Plan Combined Evidence of Coverage and Disclosure Form* (HMO), January 1, 2017 (eFiled February 4, 2016, eFiling #20160362)
- 65 Utilization Management authorization files (April 1, 2019 – March 31, 2021)

Assessment: Based on review of Santé utilization management authorization files, the Department found the processes for reviewing and authorizing certain behavioral health outpatient services are at variance with the Plan's Combined Evidence of Coverage and Disclosure Form for HMO plan (EOC). Section 1386(b)(1) includes the following as grounds for disciplinary action:

> The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

Section 1351(f) requires plans to file "forms of evidence of coverage" and disclosure forms to be issued to enrollees. The Plan submitted its application for licensure, including a copy of the Plan's EOC, on July 1, 2012, in eFiling #20121253.

Section 1352(b) requires plans to provide notice to the Department prior to a material modification of its plan or operations. The Plan filed a revised EOC with the Department on February 4, 2016, as part of a material modification in eFiling #20160362. The revised EOC filed with the Department stated the following under Section 5, subsection II, paragraph 32:

> Prior authorization for outpatient mental health and substance use disorder treatment, including facility-based care, is required if the treatment is provided by a Non-Participating Provider, but is generally not required if the treatment is provided by a Participating Provider. Prior authorization is required for the following outpatient mental health/substance use disorder services provided by a Participating

> Provider: psychological testing, electroconvulsive therapy, transcranial magnetic stimulation, MRI scans, and PET scans.

Therefore, the Plan's filed EOC states there is no prior authorization requirement for most outpatient behavioral health services when provided in network and lists those services for which prior authorization is required. Outpatient psychotherapy and medication management do not require prior authorization according to the Plan's EOC when the services are provided by a participating provider.

In connection with the Plan's BHI, the Plan provided a copy of its Large Group EOC, the Community Care Health Plan Combined Evidence of Coverage and Disclosure Form (HMO) effective January 1, 2021 (the 2021 EOC). Page 42 of the 2021 EOC includes the prior authorization language set forth above, as filed with the Department.

The Plan's log of all behavioral health services requested during the review period that required prior authorization showed that 75% of the requests were for outpatient behavioral health services, including, for example, office visits, intensive outpatient services, and partial hospitalization. Because the log should only include those services for which prior authorization is required, it appears prior authorization review was conducted on services to the extent the requests involved in-network providers, for which the EOC stated no prior authorization was required.

The Department reviewed Sante's 65 utilization management case files involving behavioral health services randomly selected from the log of services identified by the Plan as requiring utilization review. Of the 65 files reviewed, 25 files[17] involved prior authorization, 37 files involved concurrent review[18] and three files involved retrospective review.[19] Review of the 25 prior authorization files indicated that eight[20] (32%) of the case files involved requests for outpatient behavioral health services, such as psychotherapy or medication management, from contracted providers. These services do not require prior authorization according to the Plan's EOC.

Conclusion: By conducting prior authorization on outpatient behavioral health services contrary to the terms and requirements stated in the Plan's EOC, the Department finds the Plan's behavioral health delegate was operating at variance with the EOC on file with the Department in violation of Section 1386(b)(1).

#5: <u>The Plan failed to perform oversight of its behavioral health delegate to ensure enrollees' ability to obtain timely, medically necessary behavioral health services.</u>

Statutory/Regulatory Reference(s): Rules 1300.51(H), 1300.67.2 (d) and (f), 1300.67.2.2(c)(1) and 1300.70(a)(3)

[17] Utilization Management authorization File #s 1, 6, 11, 12, 13, 16, 17, 19, 20, 21, 22, 26, 29, 32, 34, 35, 37, 40, 48, 49, 52, 57, 60, 66, 67.
[18] Utilization Management authorization File #s 2, 3, 4, 5, 7, 8, 9, 10, 14, 15, 23, 24, 25, 28, 30, 31, 33, 36, 38, 39, 41, 43, 44, 45, 46, 47, 50, 51, 53, 54, 56, 58, 59, 62, 63, 64, 65.
[19] Utilization Management authorization File #s 27, 55, 61.
[20] Utilization Management authorization File #s 1, 20, 27, 34, 49, 52, 57, 67.

Supporting Documentation:

- Provider Appointment Availability Survey (PAAS Survey) Results MY 2019
- PAAS Survey Results MY 2020
- *Community Care Health Plan Timely Access Policy and Procedures* (August 8, 2019)
- *Standards of Accessibility* policy (August 8, 2019)

Assessment: Health plans must ensure covered health services, including behavioral health services, are provided in a timely manner appropriate for the nature of the enrollee's conditions. Plans must establish and maintain policies, procedures and monitoring systems to ensure compliance with this appropriateness standard.[21] Plans must also have documented systems for monitoring and evaluating accessibility of care.[22] Additionally, plans must ensure that the ratio of enrollees to health professionals reasonably assures services are accessible and appropriate without delays detrimental to enrollee health.[23] With respect to geographical access, Plans must make health care readily available in each service area to all enrollees and must demonstrate that, throughout the geographical regions of the plan's service area, services are readily available and readily accessible to all enrollees.[24] Finally, plans must have quality assurance programs to monitor whether the provision and utilization of services meets professionally recognized standards of practice.[25]

The Department requested copies of policies and procedures, audit reports and any other documents pertaining to the Plan's monitoring and oversight of its delegates to ensure compliance with timely access requirements. Although during interviews the Plan stated it used an outside vendor to conduct an annual audit of Santé, the Plan did not submit any audit, oversight or monitoring reports for any delegate or subdelegate.

The Department also requested copies of Plan reports evidencing the Plan's monitoring of geographic access and provider-to-enrollee ratios for behavioral health service providers. The Plan provided its *Standards of Accessibility* policy which sets forth the standards for provider-to-enrollee ratios, and the results of its Provider Appointment Availability Survey for Measurement Year 2019 and Measurement Year 2020. However, these documents did not demonstrate the Plan monitors, analyzes or reports on compliance with geographic accessibility standards or enrollee-to-provider ratios. Further, there was no documentation demonstrating evaluation of compliance with time and distance standards.

The Plan also provided its *Community Care Health Plan Timely Access Policy and Procedures*, which includes standards for provider-to-enrollee ratios, geographic time/distance standards and appointment access standards. This policy also sets forth requirements and procedures for compliance monitoring. However, the Plan failed to demonstrate it actually performed, documented or reported any monitoring of behavioral

[21] Rule 1300.67.2.2(c)(1).
[22] Rule 1300.67.2(f) and 1300.70(a)(3).
[23] Rule 1300.67.2(d).
[24] Rules 1300.67.2 and 1300.51(H).
[25] Rule 1300.70(a)(3).

health services for geographic accessibility compliance other than providing geographic access reports for its dental and vision delegates.

During interviews, the Plan's representative indicated the Plan monitors timely access, but stated the Plan was not aware behavioral health providers are to be included in provider-to-enrollee ratio monitoring.

Conclusion: Based on review of the Plan's submitted documentation, the Department finds that, while the Plan has policies and procedures that outline processes for monitoring access, the Plan failed to demonstrate that it monitors, analyzes or reports on compliance with timely access or geographic accessibility standards, or enrollee-to-provider ratios and does not monitor its behavioral health delegate to ensure compliance with these standards as required by Rules 1300.51(H), 1300.67.2 (d) and (f), 1300.67.2.2(c)(1) and 1300.70(a)(3).

#6: <u>The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing its delegate to perform quality assurance functions.</u>

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

Supporting Documentation:

- *Medical Group Provider Agreement* (September 2012; January 2014)
- *Medical Group Provider Agreement,* Amendment #23 (January 1, 2021)
- *Summary Description of Plan Organization and Operations* – Exhibit E-1, (September 16, 2019)
- Plan Response to BHI Questionnaire Tables
- 7 Potential Quality Issue (PQI) files (April 1, 2019 – March 31, 2021)

Assessment: The Plan and Santé entered into a *Medical Group Provider Agreement* effective January 1, 2014 (Provider Agreement).[26] As required by Section 1351(d), the Plan filed a copy of the Provider Agreement with the Department as part of the Plan's initial application for licensure.[27] Exhibit C of the Provider Agreement identified a number of delegated administrative services to be performed by Santé, including, but not limited to, professional services administration, utilization review, peer review, credentialing, quality management, and grievance procedure compliance, among others.

[26] The Plan also entered into a Management Services Agreement with Santé Health System, Inc., an affiliate of Santé, to provide administrative services to the Plan, such as call center services, claims processing, provider contracting and other administrative support services. The Management Services Agreement with Santé Health System, Inc. did not involve delegation of quality assurance functions, however, and is therefore not the subject of this violation.

[27] See original application for licensure eFiling # 20121253, filed July 1, 2012, which included a Medical Group Provider Agreement template. Subsequently, the Plan filed a Medical Group Provider Agreement on November 21, 2013 in eFiling #20132349 that identified Santé as the delegate.

The Plan and Santé subsequently amended the Provider Agreement and filed the amendment with the Department as required by Section 1352(a).[28] Although the original Provider Agreement filed with the Department delegated quality assurance functions to Santé, Amendment #23[29] to the Provider Agreement limited the delegated functions to Santé to the following:

- Claims/Provider Dispute Resolution
- Utilization Management
- Credentialing
- Case Management

Thus, during the BHI review period, Santé was not delegated responsibility for quality assurance functions, which were retained by the Plan. However, the Department's review of the Plan's potential quality issue files demonstrated Santé was conducting quality assurance functions on behalf of the Plan during the review period of April 1, 2019, through March 31, 2021.

The Plan identified seven potential quality issue files for the BHI review period. The Department reviewed all seven files[30] and found that in each case, the potential quality issue was assigned to, worked on, or reviewed by Santé or Advantek[31] employees. The case files included internal email communications between the Plan, Santé and Advantek employees in which Santé or Advantek employees were assigned to perform functions related to quality-of-care investigations, such as contacting providers to obtain information about the alleged quality of care incident and documenting aspects of quality investigations. In the case files, Santé or Advantek employees received emails addressed to the "QI [quality improvement] Team" and including individuals with titles such as "QI nurse."

In response to Department inquiries about the role of Santé or Advantek in the Plan's quality assurance operations, the Plan stated in a January 10, 2022 communication to the Department:

> The Plan confirms that it retained responsibility for the grievances/appeals and quality management functions during the review period. Since Santé Health Systems (dba Advantek) was contracted to provide customer service support under an administrative services agreement, customer service representatives were in a position to receive and resolve exempt grievances during the review period.

[28] See eFiling #20193126, filed on September 16, 2019 (including Amendment #23 to the Medical Group Provider Agreement).
[29] The Medical Group Provider Agreement was identified as Amendment #13 when eFiling #20193126 was filed on September 16, 2019, and in two subsequent amendments: eFiling #s 20193126-2 and 20193126-3. The final executed version submitted in the final amendment on January 22, 2021, eFiling #20193126-4, identified the document as Amendment #23. It is not clear whether this was a typographical error as there were no intervening Amendments numbered 14 through 22.
[30] File #1, File #2, File #3, File #4, File, #5, File #6, File #7.
[31] Advantek Benefit Administrators (Advantek), a division of Santé Health System, Inc., had an administrative contract with Santé to perform certain administrative benefits services for the Plan.

> Similarly, Advantek provided administrative support for the Plan's quality management activities during the review period pursuant to that same administrative services agreement, which was filed with and reviewed by the Department.

Accordingly, both the Plan's potential quality issue files as well as the Plan's statement, confirm Santé employees were performing quality functions on behalf of the Plan.

Section 1386(b)(1) includes the following as grounds for disciplinary action against a health plan:

> The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director. Section 1351(t) requires health plan applications for licensure to be accompanied by information reasonably required by the director.

Because quality functions were not delegated to Santé per Amendment #23 of the Provider Agreement filed with the Department, the Department finds the Plan operating at variance with the Amended Provider Agreement, in violation of Section 1386(b)(1).

Conclusion: Santé was not delegated Plan quality assurance functions. However, file review demonstrated Santé performed quality functions on behalf of the Plan, in violation of the Provider Agreement, as amended. Accordingly, the Department finds the Plan is operating at variance in violation of Section 1386(b)(1).

#7: <u>The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing the delegate to resolve grievances.</u>

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

Supporting Documentation:

- *Medical Group Provider Agreement* (September 2012; January 2014)
- *Medical Group Provider Agreement,* Amendment #23 (January 1, 2021)
- *Summary Description of Plan Organization and Operations* – Exhibit E-1, (September 16, 2019)
- Plan Response to BHI Questionnaire Tables
- 12 Grievance and Appeals files (April 1, 2019 – March 31, 2021)

Assessment: As discussed above in violation #6, the Plan and Santé entered into the Provider Agreement and filed it with the Department, both as part of the Plan's initial licensure and again when the Provider Agreement was amended. As amended, the Provider Agreement delegated the following functions to Santé:

- Claims/Provider Dispute Resolution
- Utilization Management
- Credentialing
- Case Management

During the review period, Santé was not delegated responsibility for grievance or appeal functions, which were retained by the Plan. However, statements made by the Plan during interviews and the Department's review of the Plan's grievance and appeal files demonstrated Santé was handling grievances on behalf of the Plan during the review period of April 1, 2019, through March 31, 2021.

During interviews, the Plan explained that customer service was handled by Santé through Advantek, with whom Santé had an administrative contract, and that most grievances are received through customer service. Although the Plan confirmed the Plan retained responsibility for the grievance and appeals functions, the Plan acknowledged customer service representatives were in a position to receive and resolve exempt grievances.

The Department reviewed the 12 grievance and appeals files identified by the Plan that involved behavioral health issues. The files demonstrated that Santé and Advantek employees performed certain grievance handling functions, such as assigning grievance categories and generating and mailing grievance acknowledgement letters. Additionally, a Santé or Advantek employee was identified in grievance acknowledgement letters as the person the enrollee should contact for questions about the grievance.[32] Internal grievance and appeals case file notes also included communications between Santé or Advantek employees that demonstrated the employees were performing grievance functions. For example, one file included a note from one Santé employee to another stating: "Please review. Appears to be an exempt grievance."[33] Another file included notes showing the Santé employee was making telephone calls to a provider group in efforts to resolve a grievance.[34] Other files included notes made by a Santé employee identified as a "Member Grievances & Appeals Nurse" describing the steps she took in responding to and handling a grievance.[35]

The Plan's files and the statement made by the Plan confirm that Santé or Advantek employees were performing grievance and appeal functions on behalf of the Plan.

Section 1386(b)(1) includes the following as grounds for disciplinary action against a health plan:

> The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and

[32] See, for example, Grievance and Appeal Files #2, #4, #6 and #7.
[33] See Grievance and Appeal File #5.
[34] See Grievance and Appeal File #7.
[35] See Grievance and Appeals File #8, #11 and #12.

> reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director. Section 1351(t) requires health plan applications for licensure to be accompanied by information reasonably required by the director.

Because grievance and appeal functions were not delegated to Santé (or Advantek) per the Provider Agreement, as amended, and on file with the Department, the Department finds the Plan operating at variance with the Amended Provider Agreement, in violation of Section 1386(b)(1).

Conclusion: Santé was not delegated Plan grievance and appeal functions. However, file review demonstrated Santé (or Advantek) performed grievance and appeal functions on behalf of the Plan, in violation of the Provider Agreement, as amended. Accordingly, the Department finds the Plan is operating at variance in violation of Section 1386(b)(1).

#8: <u>The Plan failed to ensure customer service staff are knowledgeable and competent regarding enrollee questions and concerns.</u>

Statutory/Regulatory Reference(s): Rule 1300.67.2.2(c)(10)

Supporting Documentation:

- Quality Improvement Oversight Committee minutes
- Delegate Oversight Committee minutes

Assessment: Rule1300.67.2.2(c)(10) requires plans to “ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.” Therefore, in addition to ensuring enrollee calls are answered within ten minutes, health plans must monitor and evaluate customer service staff to ensure staff are knowledgeable and competent so that assistance to enrollees is meaningful and effective.

When asked to provide documentation to demonstrate that the Plan monitors its and its behavioral health delegates’ customer service staff, the Plan provided Quality Improvement Oversight Committee minutes that included statistical data, such as total number of calls received by customer service staff, speed to answer and the percent of calls abandoned by the caller (abandonment rate), by month and by quarter. However, neither the Plan nor the delegate submitted policies or procedures pertaining to customer service operations that addressed performance standards, benchmarks for information accuracy or performance review requirements. No documents were submitted pertaining to training of customer service staff on behavioral health services or responding to calls for assistance in identifying available behavioral health providers, making appointments or verifying provider availability. There were also no documents such as telephone satisfaction survey results, results of customer service call audits, evidence of trainings or other documentation demonstrating quality of customer service operations is monitored, measured, recorded, or reported. The Delegate Oversight

Committee meeting minutes included no reporting of customer service operations performed by the Plan's behavioral health delegate. Therefore, although the Plan tracks statistical data for calls handled by customer service staff, it failed to implement customer service quality standards, policies or trainings and monitor, audit, report or review compliance outcomes. As a result, the Plan is unable to ensure enrollees are timely able to speak with customer service staff who are knowledgeable and competent regarding the enrollees' questions and concerns, in violation of Rule 1300.67.2.2(c)(10).

Conclusion: Because the Plan failed to demonstrate it has a process to ensure customer service staff are knowledgeable and competent regarding enrollee questions and concerns, the Department finds the Plan out of compliance with Rule 1300.67.2.2(c)(10).

GRIEVANCES AND APPEALS

#9: The Plan does not consistently identify grievance categories as required.

Statutory/Regulatory Reference(s): Rule 1300.68(e)(2)

Supporting Documentation:

- 12 Grievances and Appeals files (April 1, 2019 – March 31, 2021)

Assessment: Rule 1300.68 (e)(2) states:

> The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

The Plan identified 12 grievance and appeal files involving behavioral health issues received during the review period. In four[36] of the 12 files (33% of the files reviewed), the Plan did not identify the grievance issue as required by Rule 1300.68 (e)(2). The files included no indication the Plan identified and categorized the grievances into one or more of the six required categories.

[36] Grievance and Appeal Files #3, #5, #6 and #8.

TABLE #2
Grievance Categorization

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Grievance and Appeals Files	12	Grievance and appeals system shall describe the issue(s) raised in grievances as one or more of six designated categories	8 (67%)	4 (33%)

Conclusion: Because the Plan failed to consistently describe grievance issues using one or more of the six categories required by Rule 1300.68.01(e)(2), the Department finds the Plan out of compliance with this regulatory requirement.

CULTURAL COMPETENCY, HEALTH EQUITY AND LANGUAGE ASSISTANCE

#10: The Plan failed to provide adequate training to Plan staff concerning the Plan's language assistance program with respect to understanding the cultural diversity of the Plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Statutory/Regulatory Reference(s): Rule 1300.67.04(c)(3)(D)

Supporting Documentation:
- *Community Care Health Language Assistance Program* (October 2020)
- *CCH Monthly Compliance Training Customer Service/Operations and Legal & Regulatory Affairs* (December 21, 2020)
- CCH Team Meeting (April 9, 2021)

Assessment: The Department requested the Plan produce documents pertaining to its processes for ensuring the provision of culturally competent services, including but not limited to documented policies and procedures and Plan staff trainings pertaining to cultural competency. The Department reviewed the documents provided in response to this request.

The Plan's *Community Care Health Language Assistance Program* policy states the following with respect to training:

> Staff training: CCH will develop and provide adequate training regarding CCH's language assistance program to all plan staff and Provider offices who have routine contact with [limited English proficiency] LEP Members. This training includes instruction on:

1. Knowledge of CCH's policies and procedures for language assistance;
2. Working effectively with LEP Members;
3. Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and
4. Understanding the cultural diversity of CCH's Member population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

The Plan's December 21, 2020 *CCH Monthly Compliance Training Customer Service/Operations and Legal & Regulatory Affairs* document listed Plan staff attendees and, with respect to language assistance, stated:

> Language Assistance Program (LAP)
> Review changes of the recently approved LAP Policy

The Plan's April 9, 2021 CCH Team Meeting document listed Plan staff attendees and, with respect to language assistance, stated:

> Training – review of Grievance Policy and Language Assistance Policy

None of these documents included any details or information about training content or how the training pertained to cultural diversity relevant to the delivery of health care interpretation services.

> Every plan shall implement a system to provide adequate training regarding the plan's language assistance program to all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:
>
> (D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Based on the documents the Plan provided, the Plan was unable to demonstrate its training system is adequate for instructing Plan staff on understanding the cultural diversity of the Plan's enrollee population, or sensitivity to cultural differences relevant to the delivery of health care interpretation services. The documents included no specific content about what was included in the instruction or whether the attendees have routine contact with LEP enrollees.

Conclusion: The Department finds the Plan is in violation of Rule 1300.67.04(c)(3)(D) for failure to demonstrate it has a system to provide adequate training regarding cultural diversity for its staff who have routine contact with LEP enrollees.

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

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

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

#1: The Plan conducts utilization review for behavioral health services that do not require prior authorization.

Summary: As discussed in Knox-Keene Act violation #4 above, the Plan's utilization management review practices for certain behavioral health services were not consistent with the Plan's Evidence of Coverage filed with the Department. These practices result in unwarranted delay in providing services.

Based on the Plan's Evidence of Coverage, no utilization management review was generally required for outpatient behavioral health services provided by contracted providers. However, because utilization review for those services was conducted, enrollees' ability to obtain those services was delayed by the time taken to conduct unnecessary utilization review.

#2: The Plan does not have a policy to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy.

Summary: When asked to provide a copy of the Plan's medical policy to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy, including the Plan's medical policy for the OTPs and OBOT waiver program physicians, the Plan failed to provide any responsive documents. During interviews, the Plan acknowledged it had no policies or other documents responsive to the request.

Because office-based settings are generally more accessible to enrollees and hold less social stigma as compared to formal treatment program settings, failure to have policies addressing services provided in these settings is a barrier that unnecessarily limits the locations where opioid use disorder treatment can be provided.

#3: The Plan has not developed and implemented a comprehensive plan to identify and address disparities across its enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location.

Summary: As discussed in Knox-Keene violation #10 above, the Plan did not provide adequate evidence to demonstrate Plan staff received cultural competency training. The Plan's *Community Care Health Language Assistance Program* policy and other provided documents did not demonstrate Plan staff trainings included content that address disparities in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level or geographic location.

Similarly, in response to requests for information and questions asked during interviews regarding cultural disparities, the Plan generally described its efforts to assist enrollees with limited English language proficiency but did not address other issues pertaining to cultural competency.

Finally, the Plan was unable to provide documents describing the Plan's oversight and monitoring of its contracted providers to ensure providers meet the cultural, ethnic, racial, and linguistic needs and preferences of its membership. The documents provided, including the Provider Agreement and Amendment #23 to the Provider Agreement, did not address provider oversight, monitoring or cultural competency.

The Plan was unable to demonstrate it has a strategy to identify cultural disparities across its enrollee population, and therefore cannot know whether it is meeting the needs of its enrollees. The lack of well-developed processes to ensure cultural competency of staff and providers prevents the Plan from understanding and delivering behavioral health services that meet the needs of all enrollees.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified ten Knox-Keene Act violations and four barriers to care not based on Knox-Keene Act requirements. Furthermore, the Department identified no notable Plan initiatives or operations.

The Plan was afforded an opportunity to respond to any factual errors in this Report and submit a CAP reasonably calculated to correct the identified Knox-Keene Act violations.

The Plan may submit a statement describing actions the Plan has or will take to address the four barriers to care not based on Knox-Keene Act requirements (Barriers Statement). This separate Barriers Statement is **not** part of the corrective action plan described below, and should be submitted separately. Should the Plan wish to submit a Barriers Statement, please submit it to the Department no later than **Friday, September 8, 2023**, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.
Once logged in, follow the steps shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2021 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP and any Barriers Statement, will be posted to the **Department's website**.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Laura Beile	Supervising Health Care Service Plan Analyst
Marie Broadnax	Staff Services Manager II
Lezlie Micheletti	Health Plan Specialist II
Christian Jacobs	Health Plan Specialist II
CONSULTANT TEAM MEMBERS: THE INS COMPANIES, INC.	
Heather Harley	Project Manager
JoAnn Baldo	Investigator
Anita Edington	Investigator
Sam Muszynski	Investigator
Marilyn Vadon	Investigator
Katie Dublinski	Investigator
Donna Lee Williams	Investigator

APPENDIX B

APPENDIX B. PLAN STAFF INTERVIEWED

PLAN STAFF INTERVIEWED FROM: COMMUNITY CARE HEALTH PLAN, INC.	
Jennifer Lorge	Chief Legal and Regulation Affairs Officer
Dr. Anand Rajani	Chief Medical Officer
Judy Vaccaro	Compliance Officer and Deputy General Counsel
Brigitte Golden	Vice President Regulatory Affairs/Grievance Officer
Robert Sarkisian	Director, Quality Improvement
Diane O'Toole	Director Planning & Implementation
Kimberli Portello	Manager of Compliance Administration
Deidre Berman	Vice President, Business Development & Consumer Experience
Michele Mills	Vice President, Sales
Aldo Delatorre	President and Chief Executive Officer
DELEGATE STAFF INTERVIEWED FROM: MEDIMPACT HEALTHCARE SYSTEMS	
Michael Krasny	Formulary Audit Pharmacist
Jamie Sexton	Prior Authorization Audit Pharmacist

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries	**30**	207647 222204 228492 241486 255513 275173 284021 290076 296456 296568 298134 300083 304694 308620 316277 316293 317276 317294 308620 316277 316293 317276 317294 317872 324539 341145 342525 342586 343648 347428 348946 355590 356227 357086 403914

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management	**65**	19590 20859 19528 21298 20190102-02 20210205-01 22967 23342 20190430-01 19374 20201016-01 20201230-01 20201228-01 37840754 20191021-01 20200708-01 20200106-02 20201117-01 20191125-01 22757 20210329-01 20200921-01-55 22511 20339 21448 20200910-02 20220 20200224-01 20200305-01 20200423-02 19502 37862764 20200815-01 20940 20190802-01 22283 20200727-01-55 22112 21340 20201027-01-55 20792 20519 20142 21026 20201202-03

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management (continued)		19792 19180 20200318-01-57 19345 20190408-01 22484 19398 19754 20275 22961 19890 20580 21450 20190201-01 20210310-01-51 22277 21338 20201214-01 19618 37859368
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Potential Quality Issues	**7**	229694 255529 385867 386898 412074 415247 424503
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Requests for Out of Network Behavioral Health Provider	**5**	229694 255529 324138 374379 412074

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims	**30**	202101210760 202007150881 202008260944 202102252320 19857527 201904101080 201910151789 201905310856 201911202517 202002261053 201906210822 202103190305 20645277 202101210760 201907050529 201905010433 201904111080 202001201080 202102030583 202005210190 202102042182 202001290756 202006262302 202102252313 20726088 201905310854 201912240768 201908020357 202005110566 201906130954

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims	**30**	202003131666 202103053326 20050183 19174379 202009182411 19441681 20561089 202002170371 20724964 20135240 19315212 20503911 19781704 20770741 202009010987 201910283118 20611643 202006170865 19292772 20561113 202004202989 19207968 202012160250 19906755 201907221863 20534837 19970662 19350422 20602246 20140388

Type of Case Files Reviewed	# of Files	Case ID Number
Grievance and Appeals	**12**	209878 229694 250049 255529 283470 324138 374379 385867 386898 412074 415247 424503

COMMUNTIY CARE HEALTH PLAN, INC.
CORRECTIVE ACTION PLAN RESPONSE

June 28, 2023

Kimberly Galli
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

RE: Community Care Health Response and Corrective Action Plan to the Department's Behavioral Health Investigation (BHI) Report

Dear Ms. Galli,

Community Care Health Plan ("CCH" or the "Plan") submits the following response and Corrective Action Plan ("CAP") to the Department of Managed Health Care's (the "Department") May 26, 2023 Behavioral Health Investigation ("BHI") Report covering the period April 1, 2019 through March 31, 2021.

CCH is the smallest commercial health plan in the state, with under 10,000 members at the time of the BHI. It is the only local commercial option in the Fresno area and operates with a lean, experienced, consumer and compliance-focused staff. During the two-year investigation period, CCH offered direct access to behavioral health services (no referrals required), did not deny *any* behavioral health authorization requests since the Plan's inception in 2014, and had just 12 behavioral health related grievances. No member grievances were escalated to the Department's Help Center. No provider complaints were received by the Plan related to behavioral health services. Moreover, the Plan received no requests for language interpretation at an appointment during the investigation period. The Plan authorized *all* out of network requests for behavioral health services. The Plan believes there were minimal, if any, barriers to accessing behavioral health services during the investigation period.

Prior to January 1, 2022, the Plan contracted with a single provider group, Santé IPA, to provide professional services, including behavioral health services contracted through Bio Behavioral Medical Clinics ("BBMC"). CCH delegated the utilization management, credentialing, claims payment and provider dispute resolution functions to Santé IPA. Santé IPA sub delegated utilization management for behavioral health services to BBMC and required quarterly reporting and annual audits of BBMC to ensure legal/regulatory and contractual compliance. During the BHI process, Santé IPA terminated its agreement with CCH, necessitating the development of a new provider network and contracting for administrative services.

Effective January 1, 2022, the Plan replaced its provider network with a directly contracted physician network, Halcyon Behavioral (behavioral health), and PhysMetrics (physical medicine). CCH also contracted with Halcyon Behavioral and PhysMetrics for administrative services including but not limited to utilization management. The Plan engaged HealthComp to provide utilization management, customer service, claims payment, and provider dispute resolution services. The Department reviewed and approved the Administrative Services Agreements ("ASAs") and associated delegation oversight and monitoring amendments.

Establishing a culture of compliance has been a top priority for the Plan since its inception in 2014. This priority has continued through the January 1, 2022 transition to CCH's new network and administrative service providers. Because of its compliance focus and emphasis on consumer satisfaction, CCH used Santé IPA's termination, as well as the Department's Follow-up Routine Medical Survey and the BHI (all occurring within a few months of each other) as an opportunity to reevaluate and make improvements to its operations, policies and procedures, and delegation oversight practices. The Plan appreciates the Department's feedback shared throughout the BHI process so that it may continue to improve and establish best practices with its new delegates.

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1 - The Plan failed to demonstrate it has a process for determining geographic accessibility and timely access for medically necessary pervasive developmental disorder and autism health care services.

Background: The Department determined that the Plan does not adequately monitor and evaluate the adequacy of its network to meet the needs of enrollees with Pervasive Developmental Disorder ("PDD") and autism because it did not provide a copy of the report referenced in Rule 1300.74.73(a)(3). That Rule required plans to submit a report demonstrating an adequate network of qualified autism service providers, qualified autism service professionals and/or qualified autism service paraprofessionals to the Department no later than December 31, 2012. CCH began operations in 2014 and thus did not submit the report in 2012. The Department, however, has incorporated many (if not all of) the reporting requirements of 1300.74.73(a)(3) into its detailed and continuously evolving Annual Network Report ("ANR") templates and Timely Access Compliance filing requirements, with which CCH has complied.

The Department's Request BHIAA4_7 stated, "With respect to Pervasive Developmental Disorder (PDD) and autism services, provide copies of *documents that include a description of how* the Plan determines provider network adequacy, including how geographic accessibility and timely access are being met. Include a *report on the Plan's current network adequacy* for these services" [emphasis added]. In response, the Plan provided the following:

(1) **Exhibit J-13 Timely Access Policy & Procedures** – this document provides a description of how the Plan determines provider network adequacy, including how the Plan meets geographic accessibility and timely access requirements. Additionally, the policy outlines the compliance monitoring mechanism used by the Plan to measure the accessibility and availability of contracted providers, including but not limited to, reviewing member and provider surveys, grievances, and reporting of information available to the Plan to its Quality Improvement Oversight Committee ("QIOC"). As stated on page 1 of the policy, the processes described therein are applicable to *all* provider types, *including* PDD/autism providers in CCH's network.

(2) **MY 2019 and MY 2020 Annual Network Report ("ANR") for Qualified Autism Providers** - Plans and the Department have relied upon the ANR to report the number and location of providers for purposes of demonstrating that the Plan has an adequate network (including autism providers). The Department issued Network Findings to the Plan regarding its Qualified Autism Service ("QAS") providers for MY 2018, 2019 and 2020. The Plan's response submitted on June 8, 2022 for MY 2020 (and prior years) explained that the Plan does not contract at the individual provider level. Rather, the Plan contracts with QAS providers at the *group* level and reports the autism centers that are displayed in the Plan's provider directory under Facility, Facility Type tab of the Department's MY 2020 template. Enrollees seeking services from the QAS providers listed on the facility template have access to all the QAS providers, professionals, and paraprofessionals within those groups. Based on the Plan's analyses, there is no shortage of QAS providers in its contracted network for MY 2018, MY 2019 or MY 2020, nor were there any grievances related to accessibility of such services.

The Plan disagrees with the Department's conclusion that it violated Rule 1300.74.73(a)(3)(c). The Plan is not aware of a different geographic accessibility standard or network monitoring requirement warranting a distinct policy and procedure for PDD/autism providers that is distinct from its Exhibit J-13 Timely Access Policy & Procedure. Similarly, the Department has never required or requested a separate network adequacy report for PDD/autism, nor has it found any deficiencies related to PDD/autism services during its routine medical surveys, MHPAEA compliance audit, All Plan Letter filings or otherwise outside of the Timely Access process.

Since the BHI, the Plan implemented SB 855 and additional timely access requirements. The Department continues to review the Plan's policies and procedures in connection with those filings, including the Plan's Exhibit J-13 Timely Access Policy & Procedure (Filing No. 20230613). Furthermore, the Department has added utilization information for QAS providers to its ANR templates (see Columns O and P of the Mental Health Professional and Facility Report Form for MY 2022). This adds even more specificity to the Plan's network adequacy review and reporting for PDD/autism services.

Proposed Corrective Action:

Although the Plan disagrees with the Department's Deficiency #1, the Plan has initiated the following actions to improve its PDD/autism network adequacy monitoring:

(1) Beginning third quarter of 2023, the Plan will require Halcyon to include network and utilization data regarding PDD/autism providers in its quarterly reports to the QIOC as follows:
- Name of Member or CCH ID
- Date of Service
- Billing Provider Name and TIN
- Name of Autism Practitioner who performed the service
- NPI
- CA License or Behavior Analyst Certificate Number
- Type of License /Certificate
    - Board Certified Behavior Analyst
    - Registered Behavior Technician
- Specialty
    - Board Certified Behavior Analyst
        - Qualified Autism Service Provider
    - Registered Behavior Technician
        - Qualified Autism Professional
        - Qualified Autism Paraprofessional

(2) During the fourth quarter of 2023, and annually thereafter, the Plan will require Halcyon to prepare a Quest geographic availability analyses for its PDD/autism provider network and will present such report to the Plan's QIOC.

(3) The Plan already conducts regular training for HealthComp, Halcyon and PhysMetrics staff on a variety of regulatory and operational topics. In response to the Department's findings, CCH will conduct a training on its Exhibit J-13 Timely Access Policy & Procedure and QIOC reporting expectations. The Plan will document staff attendance with a sign in sheet and prepare minutes as evidence of the Plan's compliance with its corrective actions.

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#2 – The Plan's behavioral health delegate failed to consistently notify requesting providers of authorization decisions within 24 hours of making the decision.

Background: The Department concluded that Santé IPA's utilization management case files failed to consistently include documentation of the date and time it notified providers of utilization management decisions in violation of Section 1367.01(h)(3). As the Department is aware, Santé IPA terminated its agreement with CCH effective December 31, 2021. The Plan notes that during the investigation period, neither the Plan nor its delegate denied *any* requests for authorization of behavioral health services and no member harm resulted from any potential failure to notify the requesting provider of the authorization approval within 24 hours of making the decision.

Proposed Corrective Action: Although the Plan is unable to initiate any corrective action with Santé IPA due to its contract termination, the Plan will take the following actions with its new utilization management delegates, HealthComp, Halcyon Behavioral and PhysMetrics, to ensure compliance with of Section 1367.01(h)(3):

(1) The Plan already conducts regular training for HealthComp, Halcyon Behavioral and PhysMetrics staff on a variety of regulatory and operational topics. In response to the Department's findings, CCH will conduct a training during third quarter of 2023 of HealthComp, Halcyon Behavioral and PhysMetrics utilization management staff reminding them of their obligations to communicate authorization decisions within 24 hours of making the decision and include documentation in the enrollee's file sufficient to demonstrate the delegate notified the requesting provider timely. The Plan will document delegate staff attendance with a sign in sheet and prepare minutes as evidence of the Plan's compliance with its corrective actions.

(2) Beginning third quarter of 2023, the Plan will require HealthComp, Halcyon Behavioral and PhysMetrics to include data in its quarterly reports to the QIOC representing the number of utilization management cases notifying providers of utilization management decisions within 24 hours of making the decision, in compliance with Section 1367.01(h)(3).

PHARMACY

#3 – The Plan failed to demonstrate its pharmacy benefit manager has policies and procedures for formulary exception requests as required by state and federal laws, or that such policies and procedures were filed with the Department.

Background: The Department determined that neither the Plan nor its Pharmacy Benefits Manager ("PBM"), MedImpact, provided evidence of documented, filed processes regarding formulary exception requests. In response to request BHIPHI1_3, the Plan inadvertently supplied the Department with a copy of MedImpact's Appeals Policy, rather than its Formulary Exception Process Policy.

The Plan originally filed a copy of MedImpact's Formulary Exception Request Policy in 2017 (Filing No. 20170779) in connection with its material modification proposing to offer a prescription drug benefit. The Plan filed the policy again in March of 2022 (Filing No. 20220966) in response to an All Plan Letter issued by the Department. Additionally, the Plan provided the policy to the Department during the Department's 2019 Routine Medical Survey. The formulary exception request process is described in the Plan's Large Group and Small Group Evidences of Coverage, which have been reviewed and approved by the Department (see page 36 of the Large Group HMO EOC and page 45 of the Small Group EOC). Finally, the Plan maintains information about how to request an exception to the formulary listing on the Plan's website, as well as Plan's template pharmacy denial letters.

Proposed Corrective Action: The Plan submits the correct MedImpact Formulary Exception Request Policy(ies) in place in 2019-2021.

QUALITY ASSURANCE

#4 –The Plan's behavioral health delegate was operating at variance with its Evidence of Coverage filed with the Department.

Background: The Department concluded that the Plan's utilization management delegate for behavioral health (BBMC) conducted prior authorization on outpatient behavioral health services despite the EOC stating that no prior authorization is required for most outpatient behavioral health services. Although it appeared BBMC may have conducted prior authorization on all outpatient behavioral health services, neither the Plan nor its delegate denied any requests for authorization of behavioral health services and no member harm resulted from any potential failure to notify the requesting provider of the authorization approval within 24 hours of making the decision.

Proposed Corrective Action: The Plan cannot initiate corrective action against Santé IPA/BBMC because it terminated its agreement with the Plan on December 31, 2021. However, the Plan developed a website listing of services requiring prior authorization, as well as an online prior authorization form for easy reference by providers and enrollees. In response to the Department's findings, CCH will conduct a training during third quarter of 2023 with HealthComp, Halcyon Behavioral and PhysMetrics staff to ensure thorough understanding of which services require prior authorization review. The Plan will document delegate staff attendance with a sign in sheet and prepare minutes and materials as evidence of the Plan's compliance with its corrective actions.

#5 – The Plan failed to perform oversight of its behavioral health delegate to ensure enrollees' ability to obtain timely, medically necessary behavioral health services.

Background: The Department concluded that the Plan did not demonstrate that it monitors, analyzes or reports on compliance with timely access or geographic accessibility standards, or enrollee to provider ratios and does not monitor its "behavioral health delegate" to ensure compliance with these standards. The Department further stated that it requested policies and procedures, audit reports and other documents pertaining to the Plan's monitoring and oversight of its "delegates" to ensure compliance with timely access requirements.

The Plan is confused at the Department's statements and disagrees with its determination that the Plan was not compliant. Santé IPA was a contracted provider group in the Plan's provider network until December 31, 2021. Although the Plan delegated utilization management to Santé IPA, at no time did the Plan delegate responsibility to Santé IPA (or BBMC) for geographic accessibility, enrollee-to-provider ratios, or timely access. Rather, the Plan retained responsibility for this function and monitored its provider network, including its Santé IPA and BBMC providers, in compliance with the Knox-Keene Act and regulations as well as the Plan's Exhibit J-13 Timely Access Policy & Procedure, which details how the Plan monitors network accessibility and availability. The Plan also submits its annual Timely Access Compliance filing and ANR to the Department (using the Department's reporting templates and following the Department's instructions) demonstrating its compliance with the Knox-Keene Act and rules. These reports, analyses, policies, and meeting minutes were submitted to the Department in response to the BHI to document the Plan's extensive network monitoring.

Proposed Corrective Action: The Plan disagrees with the Department's assertion that the Plan did not monitor, analyze or report on compliance with timely access or geographic accessibility for its network providers. The Plan will, however, amend its Exhibit J-13 Timely Access Policy & Procedure to clarify the applicable enrollee-to-provider ratios for behavioral health providers. Since this policy is currently under the Department's review (Filing No. 20230613), the Plan will make revisions with the next round of responses to comments.

#6 – The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing its delegate to perform quality assurance functions.

Background: The Department asserts that because Santé Health Systems ("Advantek") was contractually engaged by CCH to perform certain administrative functions such as customer service and administrative support for the Plan's quality management activities, then Santé IPA was performing quality assurance functions in violation of its provider agreement. Although CCH, Community Medical Centers, Santé IPA and Advantek were part of a shared service model, which created a positive member experience while delivering administrative savings to make healthcare more affordable to CCH members, Advantek (a third party administrator) and Santé IPA (a provider group) are not the same entity. Each organization was engaged by CCH to

perform certain functions on the Plan's behalf. Nevertheless, both Santé IPA and Advantek terminated their agreements with the Plan on December 31, 2021.

Proposed Corrective Action: As of January 1, 2023, the Plan contracted directly with its provider network rather than an IPA or medical group. The Plan also engaged three new vendors (HealthComp, Halcyon Behavioral, and PhysMetrics) to provide certain administrative services outlined in the Administrative Services Agreements ("ASAs") filed with the Department. The Plan will continue to monitor and oversee the vendors' performance under the ASAs and initiate corrective action when warranted.

#7 – The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing its delegate to resolve grievances.

Background: The Department asserts that because Santé Health Systems ("Advantek") was contractually engaged by CCH to perform certain administrative functions such as customer service and administrative support for the Plan's quality management activities, then Santé IPA was performing grievance functions in violation of its provider agreement. As described in response to Deficiency #6, above, although CCH, Community Medical Centers, Santé IPA and Advantek were part of a shared service model, which created a positive member experience while delivering administrative savings to make healthcare more affordable to CCH members, Advantek (a third party administrator) and Santé IPA (a provider group) are not the same entity. Each organization was engaged by CCH to perform certain functions on the Plan's behalf. Nevertheless, both Santé IPA and Advantek terminated their agreements with the Plan on December 31, 2021.

Proposed Corrective Action: As of January 1, 2022, the Plan converted to a directly contracted provider network. The Plan also engaged three new vendors (HealthComp, Halcyon Behavioral, and PhysMetrics) to provide administrative services outlined in the Administrative Services Agreements ("ASAs") filed with the Department (Filing No. 20213880). During the comment and response process, the Department queried the Plan as to whether the new vendors will assume grievance functions. The Plan explained that it would retain the responsibility for all grievance and appeals functions. However, since the Plan's vendors are contracted to provide customer service, they may be in a position to receive and then resolve certain grievances efficiently and expeditiously (i.e., "exempt" grievances). The customer service representatives will distinguish between an inquiry and a grievance (expression of dissatisfaction) and will log all grievances received by phone, including exempt grievances, on the grievance intake form/log that will be forwarded to the Plan's Grievance Officer for resolution of the non-exempt grievances, and monitoring and tracking of all grievances. The Department approved the Plan's ASAs. The Plan will continue to monitor and oversee the vendors' performance and initiate corrective action if warranted.

#8 – The Plan failed to ensure customer service staff are knowledgeable and competent regarding enrollee questions and concerns.

Background: Rule 1300.67.2.2(c)(10) requires health plans to "ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." The Department interpreted this rule to require customer service operations policies and procedures, performance standards, benchmarks for information accuracy, telephone satisfaction survey results, customer service call audits, training documents or other evidence to demonstrate that quality of customer service operations is monitored, measured, recorded or reported. The Department concluded that because the Plan did not provide evidence that customer service staff are knowledgeable and competent regarding enrollee questions, the Plan is out of compliance with Rule 1300.67.2.2(c)(10).

The Plan disagrees with the Department's assertion that the Plan violated Rule 1300.67.2.2(c)(10). While the Rule may require health plans to ensure its customer service representatives are knowledgeable and competent to adequately address enrollee questions, it does not mandate a threshold for knowledge or competence, nor does it dictate the means by which health plans ensure its customer service representatives meet the needs of its enrollee population. Having written documentation or records of such competency testing/monitoring may be a best practice, but is not required under the law and failure to have such records does not amount to a violation absent evidence indicating that the Plan's customer service representatives were *not* knowledgeable and competent.

Proposed Corrective Action: The Plan provides relevant policies and procedures, regulatory communications, APLs, FAQs, member newsletters, and other written materials to its customer service representatives informed and prepared for enrollee phone calls. Training sessions are provided for more in depth topics or policy review. Customer service satisfaction surveys capture caller feedback about customer service representatives, the results of which are reported at the Plan's quarterly QIOC meetings. Call center statistics such as call volume, wait time, and abandonment rate are also reported at the QIOC meeting to ensure compliance with Rule 1300.67.2.2(c)(10). The Plan will document all customer service training and education efforts going forward.

GRIEVANCES AND APPEALS

#9 – The Plan does not consistently identify grievance categories as required.

Background: Rule 1300.68(e)(2) states that the grievance system shall track and monitor grievances received by health plans by issue category and indicate the total number of grievances received, pending and resolved. The Department found that because the Plan did not consistently identify the issue category *in the case file* that the Plan was not compliant with Rule 1300.68(e)(2). The Plan disagrees with the Department's conclusion because the Plan maintains this information on its grievance tracker log, which is then used to monitor, track and trend grievances at the Plan's quarterly QIOC meeting. The File Log submitted to the Department in connection with the BHI contains the grievance issue categories. The Plan's grievance system is compliant with the Rule and does indeed track grievances using the issue categories required.

Proposed Corrective Action: Although the Plan does not believe Rule 1300.68(e)(2) mandates the category be displayed in a particular manner, the Plan will begin uniformly including the grievance issue category in the enrollee's file.

#10 – The Plan failed to provide adequate training to Plan staff concerning the Plan's language assistance program with respect to understanding the cultural diversity of the Plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Background: The Department determined that the Plan violated Rule 1300.67.04(c)(3)(D) because it was unable to provide "details or information about training content or how the training pertained to cultural diversity relevant to the delivery of health care interpretation services." Rule 1300.67.04(c)(3)(D) does not specify the type of documentation or evidence of training required. CCH is a small plan with membership primarily comprised of hospital employees whose first language is English. The Plan has a Language Assistance Program ("LAP"), it conducted staff training and documented the training with an agenda and participant listing. The Plan had no requests for interpreters at appointments or translation of documents during the investigation period, and no complaints from providers or members relative to language assistance or cultural diversity.

Proposed Corrective Action: The Plan disagrees with the Department's conclusion that the Plan did not provide adequate training concerning the Plan's language assistance program. Nevertheless, in response to the Department's findings, CCH will conduct a staff training on LAP during third quarter of 2023. The Plan will document attendance with a sign in sheet and prepare minutes and meeting materials as evidence of the Plan's compliance with its corrective actions.

With respect to Section II: Barriers to care not based on Knox-Keene Act deficiencies, the Plan acknowledges and appreciates the Department's suggestions for improvements to its operations.

The Plan reiterates its commitment to continually improving the quality of service it provides to its members, providers, and customers and appreciates the Department's feedback provided during the BHI process. CCH takes the Department's findings seriously and looks forward to continuing collaboration and demonstrating the progress made.

Should the Department have any questions or wish to discuss any of the actions taken by the Plan, please feel free to contact me.

Sincerely,

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