DEPARTMENT OF
Managed
Health Care

BEHAVIORAL HEALTH INVESTIGATIONS

Phase One Summary Report 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 under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets.

The Department is conducting behavioral health investigations (BHIs) of all full-service commercial health plans regulated by the Department, with the intent to investigate an average of five health plans per year. The purpose of the BHIs is to understand any challenges enrollees are experiencing accessing behavioral health services. By focusing on health plan operations specific to behavioral health care and exploring the enrollee and provider experience, the Department can identify any violations of law as well as other barriers experienced by enrollees when obtaining, and experienced by providers in delivering, medically necessary behavioral health care services. The investigations are separate from the Department's routine medical surveys, or audits, which are conducted every three years.

This Phase One Summary Report includes a list of the Knox-Keene Act violations that were identified for each of the investigated health plans,[1] and provides a summary of other barriers to care. Barriers to care may include health plan practices, policies, operations, or other activities that may not rise to a violation of the law, but may contribute to challenges, delays or obstacles faced by enrollees as they navigate the health plan's system to access behavioral health services. Barriers can negatively impact enrollees' ability to obtain behavioral health care.

Key Knox-Keene Act Violation Findings:

- Three health plans had at least one appointment availability and timely access violation. These violations inhibit an enrollee's ability to obtain timely assistance from health plan representatives or the ability for an enrollee to obtain a timely and geographically accessible behavioral health appointment.
- Three health plans had at least one utilization management violation. These violations may lead to enrollees and/or providers receiving delayed notification of a health plan's utilization management decision and inconsistent application of utilization management criteria.
- Four health plans had at least one quality assurance violation. These violations may result in health plans or their delegated entities inappropriately changing behavioral health care service requests, inconsistent application of utilization management criteria and enrollees receiving inconsistent information from health plan representatives.

[1] A full description of each Knox-Keene Act violation can be viewed in the health plans' individual BHI reports, available on the Department's website.

- Four health plans had at least one grievance and appeals violation, which could lead to enrollee grievances not being reviewed by the health plan, inconsistent application of policies and procedures and delays in notifying enrollees of their health care rights.
- Two health plans had a cultural competency-related violation. Health plans are required to assess their enrollment population to understand the cultural diversity of their enrollees and ensure the health plan is providing culturally competent care. Without appropriately assessing the cultural needs of their enrollees, care may be delayed, misunderstood by the enrollee when interpretation services are not provided, or no care is provided at all.

Key Barrier Findings:

- Three health plans were identified as not having a process for providing integrated behavioral health care services. Although not required under the law, integrating and coordinating behavioral health care services in the primary care setting has been shown to result in a greater uptake in behavioral health care services, particularly for enrollees who are seeking behavioral health care for the first time.

- Two health plans are conducting utilization management for behavioral health care services that, according to the plans' Evidence of Coverage or policies and procedures, are not subject to prior authorization, which could result in inappropriate denials or delays in care. Although prior authorization by a health plan is not prohibited under law, health plans must conduct prior authorization reviews consistent with the requirements in law and their Evidence of Coverage, including using appropriate criteria and in parity with medical surgical services.

- Two health plans were unable to demonstrate they cover office-based opioid treatment and opioid treatment program therapy services. Current law requires coverage of these treatments, but is not specific regarding the setting. However, without offering these office-based services, enrollees are limited in where they can obtain opioid treatment.

- Five health plans did not have a comprehensive plan to identify potential disparities related to age, race, culture, sexual orientation, gender identity, income level and geographic location. Having robust policies and procedures in place to identify these disparities could reduce diagnostic errors and harmful treatment interactions, inappropriate care transitions and negative responses to medications. One additional plan used company-wide national data to develop their plan rather than using California or county specific data.

- One health plan's provider complaints involved disagreement and misunderstanding about contract rates and payment amounts.

- One health plan and its behavioral health delegate lack customer service policies and procedures to ensure proficient, effective, and appropriate customer service for enrollees.

The health plans were provided an opportunity to submit a separate written response to the barriers identified in each health plan's respective report, describing any steps taken or to be taken to address the barriers (Barriers Statement). The individual BHI Report for each of the health plans, along with each health plan's corrective action plan to address the Knox-Keene Act violations in the plan's report, and any Barriers Statement, can be found on the Department's Website. The Knox-Keene Act violations noted in the BHI Reports, along with corrective action plans, will be referred to the Department's Office of Enforcement to evaluate and take appropriate enforcement actions, which may include corrective actions and administrative penalties. For the barriers not related to Knox-Keene Act violations, the Department provided recommendations to assist health plans in considering ways to address barriers and improve access to timely, appropriate behavioral health care for all enrollees. The barriers, recommendations and health plan actions may serve to inform future statutory and/or regulatory changes.

INTRODUCTION AND BACKGROUND

The DMHC utilizes a variety of regulatory tools to assess whether enrollees are able to obtain timely access to behavioral health care services, including routine medical surveys, federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) focused surveys, annual review of health plan provider networks, reviewing health plan annual timely access compliance reports, and tracking and trending enrollee complaints and independent medical review applications to identify enrollee complaint patterns from year to year.

Effective January 1, 2021, health plans are required to cover medically necessary treatment of all behavioral health conditions recognized by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, regardless of age or product type, as required by Senate Bill (SB) 855 (Wiener, 2020). In addition, SB 855 established a statutory definition of "medically necessary treatment" for purposes of mental health and substance use disorder treatment and requires plans to use the clinical criteria developed by non-profit associations for the relevant clinical specialty. The Department issued guidance to the plans requiring them to demonstrate compliance with SB 855 and is in the process of promulgating regulations related to the implementation of SB 855. The Department will monitor compliance with these requirements through the routine medical survey process.

In addition, beginning July 1, 2022, health plans are required to ensure that their contracted provider networks can offer non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment, or longer if the treating provider determines a longer wait time will not have a detrimental impact on the health of the enrollee, as required by SB 221 (Wiener, 2021). SB 221 also requires health plans to arrange coverage outside of the plan's contracted network if medically necessary treatment of a mental health or substance use disorder is not timely available with an in-network provider. The Department has incorporated these requirements into the annual timely access filing and annual review of provider networks. In addition, the Department will monitor compliance through the routine medical survey process.[2]

Notwithstanding this rigorous oversight of access to behavioral health care services, many enrollees continue to experience difficulty accessing timely behavioral health care services. Based on stakeholder feedback as well as complaints to the DMHC's Help Center, enrollees often experience challenges finding in-network providers that are accepting new patients and scheduling timely initial and follow-up appointments. Even when an enrollee successfully connects with a provider, the enrollee may face additional obstacles in obtaining care due to health plan or health plan delegate's clinical guidelines that may limit or delay initial authorizations, treatment durations or covered services. As a result, many enrollees abandon their efforts to seek in-network care and may subsequently pay out-of-pocket for behavioral health care services with

[2] The review period for the health plans' BHIs were April 1, 2019 through March 31, 2021, prior to enactment of SB 221. Therefore, the health plans' compliance with SB 221 requirements were not evaluated as part of their BHI, but will be assessed through the Department's routine medical survey process.

an out-of-network provider, seek costly care in hospital emergency rooms or county inpatient centers, or may not obtain medically necessary behavioral health care. The BHIs include assessment of the health plans' behavioral health delivery system, including the operations of any behavioral health delegate, with a focus on the enrollee experience. [3]

The full-service commercial health plans subject to the BHIs are investigated in phases. The Department selected the plans based on enrollment size, counties of operation, and how the plan provides behavioral health services to their enrollees, such as the use of a specialized behavioral health plan. In addition, the Department sought to avoid scheduling the investigations near or during a Department routine medical survey. Phase One Summary BHI Report describes the findings of the following health plans:

- Cigna HealthCare of California, Inc.
- Community Care Health Plan, Inc.
- Contra Costa County Medical Services (Contra Costa Health Plan)
- Sutter Health Plan (Sutter Health Plus)
- County of Ventura (Ventura County Health Care Plan)

METHODS

To evaluate health plan operations, the Department requested and reviewed documents, files and data of the health plan and any behavioral health and/or pharmacy delegates. The Department also conducted interviews with health plans and delegates.

To further understand potential barriers to care from the perspective of enrollees and providers, the Department separately interviewed enrollees and providers about their experiences with the health plans.

The BHIs 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

REVIEW OF NON-QUANTITATIVE TREATMENT LIMITS (NQTLS)

The Consolidated Appropriations Act of 2021 amended MHPAEA to require plans and issuers to provide a comparative analyses of their non-quantitative treatment limitations

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

(NQTLs) to the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services (collectively, the Secretaries), and to state regulators upon request, and to authorize the Secretaries to determine whether those NQTLs comply with MHPAEA.

The Department received a request from stakeholders to include a review of the NQTL comparative analysis in the BHIs. In response, the Department requested the NQTL comparative analysis from the health plans included in this first phase review. However, during the Department's review, it was determined the review of the plans' NQTL comparative analyses was complex and would have taken significant time to determine whether they were in compliance which would significantly delay the release of the BHI reports. As a result, the Department determined a review of the NQTL comparative analysis is more appropriate for a separate compliance project, which the Department is working on outside of the BHIs.

SUMMARY OF KNOX-KEENE ACT VIOLATIONS

The Department identified 21 separate Knox-Keene Act violations that, in some instances, applied to multiple health plans.

	Knox-Keene Act Violations	Health Plans
Appointment Availability and Timely Access		
1	Failure to ensure the waiting time for an enrollee to speak by telephone with a knowledgeable and competent health plan customer service representative did not exceed 10 minutes. Rule 1300.67.2.2(c)(10)	• Contra Costa Health Plan
2	Failure to implement prompt corrective action when provider appointment availability monitoring revealed the behavioral health network was not sufficient to ensure timely access. Rules 1300.67.2.2(d)(3) and 1300.67.2.2(g)(2)(C)	• Contra Costa Health Plan
3	Failure to monitor provider referrals and specialist care as required by Rule 1300.67.1(e)	• Ventura County Health Care Plan
4	Failure to have a process for determining geographic accessibility and timely access for medically necessary pervasive developmental disorder and autism health care services. Rule 1300.74.73(a)(3)	• Community Care Health Plan, Inc.
Utilization Management, including Triage and Screening		
5	Health plans, or their behavioral health delegates, are operating at variance with utilization management policies and procedures filed with the Department. Section 1351 or Section 1352(a) or (b)	• Cigna HealthCare of California, Inc. • Contra Costa Health Plan

6	Failure to consistently notify requesting providers of utilization management decisions within 24 hours of making the decision. Section 1367.01(h)(3)	• Community Care Health Plan, Inc. • Contra Costa Health Plan
7	Failure to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	• Cigna HealthCare of California, Inc.
Pharmacy		
8	Failure to demonstrate the 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**.** Sections 1367.24 (a)(d) and (k); 45 C.F.R. 156.122(c)	• Community Care Health Plan, Inc.
Quality Assurance		
9	Failure to establish and implement a quality assurance process that assesses and evaluates compliance with utilization management requirements. Rule 1300.70(a)(3) and Rule 1300.70(c)	• Contra Costa Health Plan
10	Failure to ensure only appropriately licensed health care professionals modify requests for services and failure to send providers and enrollees written notification letters required for modifications. Additionally, the Plan's behavioral health delegate is operating at variance with its utilization management policies and procedures filed with the Department. Statutory/Regulatory Reference(s): Sections 1386(b)(1), 1367.01(e) and 1367.01(h)(4)	• Sutter Health Plus • Ventura County Health Care Plan
11	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)	• Community Care Health Plan, Inc.
12	The Plan is operating at variance with its filed Medical Group Provider Agreement by allowing its delegate to resolve grievances. Section 1386(b)(1)	• Community Care Health Plan, Inc.
13	Failure to perform oversight of behavioral health delegate to ensure enrollees are able to obtain timely, medically necessary behavioral health services. Rules 1300.67.2.2(c)(1), 1300.67.2(f), 1300.70(a)(3), 1300.67.2(d), 1300.67.2, and 1300.51(H)	• Community Care Health Plan, Inc.
14	Operating at variance with its filed Medical Group Provider Agreement by allowing the delegate to perform quality assurance functions. Sections 1351, 1352(a), (b), 1351(d), 1386(b)(1)	• Community Care Health Plan, Inc.

15	Failure to consistently review quality of care and performance of medical personnel when a potential quality issue is identified. Section 1370 and Rule 1300.70(a)(1)	• Sutter Health Plus • Ventura County Health Care Plan
16	Failure to ensure customer service staff are knowledgeable and competent regarding enrollee questions and concerns. Rule 1300.67.2.2(c)(10).	• Community Care Health Plan, Inc.
Grievances and Appeals		
17	Failure to consistently identify grievance categories as required. Rule 1300.68(e)(2)	• Community Care Health Plan, Inc.
18	Failure of customer service representatives to identify all enrollee grievances. Rule 1300.68(a)(1)	• Contra Costa Health Plan • Sutter Health Plus
19	Failure to consistently notify grievant of the right to contact the Department regarding urgent grievances. Section 1368.01(b) and Rule 1300.68.01(a)(1)	• Cigna HealthCare of California, Inc.
Claims Submission and Payment		
20	Failure to timely pay claims. Section 1371(a)(1)	• Contra Costa Health Plan
Cultural Competency, Health Equity and Language Assistance		
21	Failure to provide adequate training to health plan staff concerning the health plan's language assistance program with respect to understanding the cultural diversity of the enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services. 1300.67.04(c)(3)(D)	• Community Care Health Plan, Inc. • Contra Costa Health Plan

OTHER BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS & RECOMMENDATIONS FOR IMPROVEMENT.

The Department identified six barriers to care for the health plans reviewed in this first phase. Several of the barriers apply to multiple health plans. Each barrier is described in detail below.

Appointment Availability and Timely Access

1. <u>Health plans do not have a process for providing integrated behavioral health services.</u>

Impacted Health Plans: Contra Costa Health Plan, Sutter Health Plus, and Ventura County Health Care Plan

Behavioral health integration is an approach to delivering behavioral health care that involves primary care and behavioral health providers working together using a team-based approach. Behavioral health conditions such as depression or anxiety can co-

occur as a result of, or in response to, medical conditions including pain or other serious medical conditions.

Research conducted for the U.S. Department of Health and Human Services indicates that when enrollees have psychological or behavioral problems, they primarily turn to primary care providers for care, rather than traditional behavioral health providers[4]. Frequently, enrollees develop positive, ongoing relationships with their Primary Care Physicians (PCPs) and integrating behavioral health care within those primary care settings enables easy access and "one-stop shopping" for coordinating medical and behavioral health care services.

The traditional approach to treating behavioral health conditions is to refer an enrollee outside the primary care setting to a psychologist, psychiatrist or other behavioral health care professional. However, even when PCPs refer enrollees to behavioral health professionals, enrollees do not always end up making, obtaining or keeping appointments.

Three health plans did not have policies, procedures or procedure codes related to integrated behavioral health care services, which indicates these health plans have no method for identifying enrollees who may benefit from integrated services, no internal processes for establishing or monitoring integrated services or procedure codes that allows billing for integrated behavioral health care services.

Recommendation and other Considerations

The Department recommends that all health plans regulated by the Department have policies and procedures for integrated behavioral health care services. The health plans should also have a process for providers to be reimbursed for providing behavioral health integration services, use Current Procedural Terminology (CPT) codes for billing, and collect these CPT codes through fee-for-service billing processes or encounter data when reimbursement occurs through capitation. The health plans should use this data to measure and analyze potential improvement of physical and behavioral health outcomes, care delivery efficiency, and enrollee experience.

The recommendation is partially based on the fact that behavioral health integration is already beginning to become part of the California delivery system. For example, on January 1, 2021, the California Department of Health Care Services (DHCS) launched the Behavioral Health Integration Incentive Program, which was funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The program incentivizes improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's network, using culturally and linguistically appropriate teams with expertise in primary care, substance use disorder

[4] U.S. Dept. of Health & Human Services, Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy *Implementation Barriers to and Facilitators of Screening Brief Intervention, Referral, and Treatment (SBIRT) in Federally Qualified Health Centers (FQHCs)* (March 31, 2015) https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/131166/SBIRTbarr.pdf (as of April 27, 2022).

conditions, and mental health conditions and who deliver coordinated comprehensive care for the whole patient.

PCPs serve as an important entry point for enrollees to receive or be connected to behavioral health care services and enrollees could greatly benefit from integrated services. In particular, enrollees who are attempting to access behavioral health care services for the first time or those with undiagnosed conditions, would receive the greatest benefit from integrated behavioral health care services due to the coordinated care, where communication is facilitated across disciplines.

Utilization Management, including Triage and Screening

2. <u>Health plans conduct utilization management for behavioral health services that are not subject to prior authorization</u>.

Impacted Health Plans: Community Care Health Plan, Inc. and Contra Costa Health Plan

Utilization management is a process health plans use to determine whether a requested service is medically necessary for a particular enrollee's condition. Health plans determine which services are subject to utilization management review and which are not. Utilization management often involves reviewing the enrollee's clinical information against a set of criteria. If the criteria are met, the requested service is considered medically necessary, and the health plan authorizes the service.

Where no prior authorization is required, an enrollee may directly make an appointment or otherwise obtain the service. Conducting utilization management can be time consuming as the health plan may request the provider submit clinical records or a peer-to-peer discussion with the provider, and may take additional time to determine whether the requested service is medically necessary. Although health plans are permitted to conduct utilization management, when conducted unnecessarily and without justification, the process of utilization management may result in undue, unreasonable and needless delays for enrollees who must wait to obtain the requested service. Obtaining the service without authorization may result in the health plan denying coverage. Additionally, unnecessary utilization review requirements can result in additional administrative work for providers who set aside time to complete treatment authorization request forms or call the health plan to request services and submit clinical information.

A review of utilization log data and case files concluded that two of the health plans in phase one conduct prior authorization utilization management for services not subject to prior authorization, either according to the health plan's Evidence of Coverage[5] or the plan's policy and procedure.[6]

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[5] Community Care Health Plan's Evidence of Coverage and Disclosure Forms (January 1, 2021) states prior authorization is not required for mental health outpatient monitoring of drug therapy, or for outpatient mental health services, including psychotherapy, when provided by contracted providers.

[6] Contra Costa Health Plan's Utilization Review Criteria and Guidelines, #UM15.002, states no prior authorization is required for one initial visit and seven follow up visits for mental health outpatient

Recommendations and other Considerations

The health plans and behavioral health delegates should routinely review their utilization management policies and procedures, Evidences of Coverage and other pertinent documents to ensure application of utilization management criteria and processes are consistent with policies and procedures, processes and other documents. Health plans should also evaluate the bases for determining which behavioral health services are subject to prior authorization and consider elimination of utilization management for basic services that are most frequently authorized.

Pharmacy

3. Health Plans did not demonstrate they cover Office Based Opioid Treatment and Opioid Treatment Program Therapy services.

Impacted Health Plans: Community Care Health Plan, Inc. and Contra Costa Health Plan

Office Based Opioid Treatment (OBOT) involves a specially credentialed physician prescribing certain drugs to prevent opioid withdrawal and reduce cravings for opioid drugs (opioid agonist medications) during routine office visits. It does not include counseling. Opioid Treatment Programs (OTPs) provide more intensive treatment with prescribed medication and other forms of therapy, including individual and group counseling. OTPs must obtain certification and accreditation through a process administered by the federal Substance Abuse and Mental Health Services Administration and meet other federal requirements.[7] Providing OBOT and OTP services in office-based settings offer greater accessibility to enrollees and hold less social stigma as compared to formal treatment program settings.

Community Care Health Plan was unable to demonstrate it has policies or procedures for OBOT and OTP.[8] The health plan could not show how it handles requests for these services or whether, or under what circumstances it provides access for enrollees to these services. Contra Costa Health Plan did not include the procedure codes used to provide coverage for delivery of Opioid Use Disorder treatment in their list of covered services implying that these services are not covered. Without access to OBOT and OTP, enrollees are limited to where they can obtain opioid use disorder treatment.

Recommendations and other Considerations

As applicable, health plans should evaluate whether to conduct medical management for OBOT and OTP in the first instance in order to improve access to opioid use

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monitoring of drug therapy or for mental health outpatient services, including psychotherapy. After the initial visit and seven follow-up visits, prior authorization is required for these services. Similarly, the Utilization Management, #UM15.003 policy states no referral is required for outpatient services provided by a contracted provider, and for mild to moderate mental health services, enrollees may self-refer.

[7] 45 C.F.R. 156.122(c)(1)-(3).

[8] Although none of the five health plans in phase one produced policies or procedures pertaining to OBOT and OTP, Cigna Healthcare of California, Sutter Health Plus and Ventura County Health Care Plan each provided a response stating they do not conduct medical management for these services and therefore, because they do not require prior authorization to obtain these services, lack of policies and procedures do not create a barrier for enrollees.

disorder treatment. For health plans that continue to conduct medical management, they should develop and implement policies and procedures pertaining to OBOT and OTP, and expand access to telehealth services when appropriate.

Cultural Competency, Health Equity and Language Assistance

4. <u>Health Plans lack a comprehensive plan to identify and address disparities across their enrollee population in accessing behavioral health services due to age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location</u>.

Impacted Health Plans: Community Care Health Plan, Inc., Cigna HealthCare of California, Inc., Contra Costa Health Plan, Sutter Health Plus, and Ventura County Health Care Plan

Studies suggest that lack of cultural competency in the health care setting can result in adverse patient safety events.[9] Health care services rendered without consideration of cultural and linguistic needs and circumstances may result in diagnostics errors, unexpected negative responses to medication, harmful treatment interactions from simultaneous use of traditional medicines, inappropriate care transitions, and inadequate patient adherence to provider recommendations and follow-up visits.[10]

Additionally, there are indications showing racial minorities are less likely to have adequate access, seek help and have their mental health disorders diagnosed.[11] LGBTQ populations experience higher rates of mental disorders such as anxiety and depression, have higher rates of suicidal ideation and are subject to more emotional, physical and sexual trauma than straight and cisgender people.[12]

At a minimum, health plans are required to have a language assistance program that assesses the plan's enrollee population to develop a demographic profile and survey the linguistic needs of enrollees.[13] Additionally, plans must provide training regarding the language assistance program to plan staff who have routine contact with limited English proficient enrollees.[14] However, cultural competency is broader and encompasses more than language. Contra Costa Health Plan, Sutter Health Plus, Ventura County Health Care Plan, and Community Care Health Plan, Inc. lacked sufficient processes, procedures, policies, and operations necessary to identify and address cultural disparities in the health plans' commercial enrollee population. Additionally, Cigna Healthcare of California's cultural, language, demographic and population needs assessment activities are conducted on a company-wide, national basis and lack focus on California needs.

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[9] Brach et al., *Cultural Competency and Patient Safety* (December 27, 2019) <https://psnet.ahrq.gov/perspective/cultural-competence-and-patient-safety#> (as of April 27, 2022).
[10] *Id.*
[11] Rice & Harris, *Issues of cultural competence in mental health care* (November 2020) Journal of the American Pharmacists Association <https://www.japha.org/action/showPdf?pii=S1544-3191%2820%2930530-6> (as of April 27, 2022).
[12] Butler et al., Improving Cultural Competence to Reduce Health Disparities (2016) <https://www.ncbi.nlm.nih.gov/books/NBK361118/> (as of April 27, 2022).
[13] Rule 1300.67.04(c)(1).
[14] Rule 1300.67.04(c)(3)(D).

Recommendations and Other Considerations

Health plans and behavioral health delegates should develop and implement comprehensive and effective programs for staff and participating providers to ensure behavioral health care services are provided in a culturally competent manner that address the needs of the enrollee population. These programs should ensure adequate training is provided, monitored and documented. Health plans and their behavioral health delegates should also evaluate and document implementation of the strategies, methods, and requirements stated in their policies and procedures related to cultural and linguistic competency and assess the effectiveness and impact of implementation on enrollees and providers to further develop and improve their cultural competency practices.

Enrollee and Provider Experience

5. <u>Provider complaints involving contract rates and disputed payment amounts</u>.

Impacted Health Plan: Cigna HealthCare of California, Inc.

Health plans, their behavioral health delegates, and contracted providers must work together and communicate well to successfully fulfill each of their roles in providing care to enrollees. Miscommunication can lead to misunderstanding, frustration and ultimately, impede care provided to enrollees. When misunderstandings involve reimbursement rates or payments to a provider, the consequences can include loss of providers in the health plan's network.[15]

When contracted providers disagree with a health plan's interpretation of contract terms, contract rates or other terms of their health plan-provider agreement, providers may become frustrated, or feel as though the health plan is taking advantage of them. Health plan or delegate responses to provider grievances that do not provide clear information may exacerbate the problem. Misunderstandings between contracted providers and the health plan or delegate may result in providers electing to discontinue their contract with the health plan, avoid providing services to the health plan's enrollees and/or choosing to provide services on a fee-for-service basis only, thereby reducing the number and availability of network providers.

Provider complaints submitted to Cigna HealthCare of California, Inc. concerning contract rates and payments, and the health plan's (or its delegate's) responses to those complaints revealed disagreement and misunderstanding between contracted providers and Cigna Healthcare of California or its delegate, Evernorth, concerning applicable contract terms and reimbursement rates. Providers believed they were not paid in accordance with contract terms. The responses of the health plan or its delegate did not always provide sufficient clarity or information to substantiate the determination.

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[15] One study found mental health providers cited low reimbursement rates as a reason for not wanting to participate in a network (see Kyanko et al. *Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured*, Medical Care vol 51, 8 (August 2013) pp. 699-705. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707657/> (accessed June 2, 2023).

The provider complaints demonstrated miscommunication and misunderstanding between the health plan, its delegate and the behavioral health providers.

Recommendations and Other Considerations

Cigna HealthCare of California, Inc. should consider developing strategies for assessing and addressing the potential impact of provider complaints on the health plan's network, on the quality of care provided to enrollees, on how the health plan may be perceived by prospective providers considering contracting with Cigna HealthCare of California, Inc. and other issues that can arise from payment disputes.

6. Neither the Health Plan nor its behavioral health delegate have customer service policies and procedures to ensure proficient, effective, and appropriate customer service for enrollees.

Impacted Health Plan: Community Care Health Plan, Inc.

A. Customer service operations lack standardized policies and procedures.

The Department requested documents reflecting how the Plan measures the quality of customer service provided to its enrollees. The Plan provided no Plan or delegate policies, procedures or documents related to the customer service operations, performance standards or benchmarks, or performance review of customer service staff.

B. The system used by customer service to document enrollee telephone calls is insufficient to permit management to track and trend service inquiries.

The Plan uses a system called Manuscript Fogbugz to document the contact information of persons who call customer service. The Plan stated the system captures the name of the caller and/or enrollee, phone number, member identification number, preferred language, and the type of call. The system permits recording of whether the matter involves a grievance and the nature of the grievance, but does not track repeat callers. The Plan indicated none of the system fields are auto populated. The system allows customer service staff to enter additional information in a notes field, but there are no prompts to indicate what information should be recorded, and Plan has not demonstrated that any training or job aids have been made available to staff regarding documenting in the system. Given the limited number and type of fields, the system does not encourage customer service staff to thoroughly document incoming telephone calls or allow Plan staff to run reports that track and trend patterns or issues. These limitations impede the Plan's ability to timely identify issues raised by enrollees or permit the Plan to address or correct problems because limited information is documented.

C. The Plan does not have an adequate and effective process to monitor customer service operations.

Apart from limited information included in Quality Improvement Oversight Committee minutes, the Plan submitted no documentation to demonstrate that the oversight activities described it is Customer Service Quality Program actually occurred. Quality Improvement Oversight Committee meeting minutes included data for 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, the Plan provided no copies of telephone satisfaction survey results, results of customer service call audits, evidence of trainings or other documentation demonstrating the quality of customer service operations is monitored, measured, recorded, or reported. Additionally, Delegate Oversight Committee meetings included no reporting of customer service operations performed by the Plan's behavioral health delegate. Failure to monitor customer service staff operations prevent the Plan from identifying, tracking, and trending critical issues such as availability, accessibility, and quality of service issues.

Recommendations and Other Considerations

Community Care Health Plan, Inc. is encouraged to develop robust policies and procedures designed to ensure it monitors and evaluates the quality of its customer service operations, including assessment of performance of staff against objective standards or benchmarks. Additionally, the Department recommends the Plan evaluate the customer service documentation system used by its customer service staff and implement trainings and job aids needed to ensure customer service staff thoroughly document communications, so the Plan is able to track and trend issues raised by enrollees. The Plan should consider implementing regular reporting of customer service operations to ensure the Plan and its delegate adequately monitor and address issues received through customer service communication. Finally, the plan should evaluate its system, Manuscript Fogbugz, to ensure that it can be utilized to track enrollee contact interactions fully and all fields needed to monitor this process and be auto populated.

CONCLUSION

The Department identified 21 separate Knox-Keene Act violations that in some instances, applied to multiple health plans. Additionally, through document review, interviews with the health plans and their delegates, as well as interviews with enrollees and providers, the Department identified six separate barriers to care, several of which were identified as applying to multiple health plans.

All Knox-Keene Act violations were referred to the Department's Office of Enforcement along with corrective action plans submitted by each health plan for their respective violations.

The identified violations and barriers to care impede enrollees' ability to obtain behavioral health services. Health plans are responsible to establish operations, processes and procedures and business models that assist enrollees rather than hinder their access to care. Additionally, the results of the BHIs demonstrate that behavioral health providers experience barriers in attempting to provide timely and appropriate care. Health plans must make necessary changes to improve access to needed behavioral health care for all Californians.