DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

Contra Costa County Medical Services
DBA Contra Costa Health Plan

AUGUST 31, 2023

Behavioral Health Investigation
Contra Costa Health Plan
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 Contra Costa Health Plan (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 (PBM), PerformRX, on November 8 and 9, 2021.

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

1. The Plan failed to implement prompt corrective action when provider appointment monitoring revealed the behavioral health network was not sufficient to ensure timely access.
2. The Plan failed to ensure the waiting time for enrollees to speak by telephone with a plan customer service representative did not exceed 10 minutes.
3. The Plan failed to consistently notify the requesting provider of authorization decisions within 24 hours of making the decision.
4. The Plan is operating at variance with its filed utilization management policy.
5. The Plan failed to establish and implement a quality assurance process that assesses and evaluates compliance with utilization management requirements.
6. Failure of customer service to identify all grievances.
7. The Plan failed to timely pay claims.

[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.

8. 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 the following four barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, Utilization Management, Pharmacy and Cultural Competency, Health Equity and Language Assistance:

1. The Plan does not have a process for providing integrated behavioral health services.
2. The Plan conducts utilization management review for behavioral health services that are not subject to prior authorization, which may delay access to services.
3. The Plan does not cover Opioid Use Disorder treatment in an office-based or telehealth setting.
4. 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 and gender identity, income level and geographic location.

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 and Addiction Equity Act

(MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

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

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations (NQTLs) 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 (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

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

- 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. In connection with the Plan's BHI, the Department interviewed one provider in August 2021 who services Contra Costa County and raised concerns about the Plan's time-consuming credentialing requirements. Despite the Department's attempt to engage Plan enrollees, the Department received no response from Plan enrollees willing to be interviewed.

PLAN BACKGROUND

The Plan received its Knox-Keene license in 1978. The Plan is a public agency established to operate the Local Initiative for Contra Costa County under the California Department of Health Care Services Strategic Plan for expanding Medi-Cal Managed Care. The Contra Costa County Board of Supervisors exercises oversight through a Joint Conference Committee of the Board of Supervisors. The Plan primarily serves Medi-Cal enrollees, with a total enrollment of 208,104 enrollees, including 200,572 Medi-Cal enrollees and 7,530 commercial enrollees covering the Plan's county employees and In-Home Supportive Services (IHSS) workers.[6] The BHI did not extend to the Plan's Medi-Cal line of business and was limited to the Plan's commercial line of business, including its county employee and IHSS products. For behavioral health services, the Plan contracts with the County Mental Health provider network and provides a nurse line that is available at all times. For pharmacy benefits, the Plan utilizes a PBM, PerformRX.

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

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: The Plan failed to implement prompt corrective action when provider appointment monitoring revealed the behavioral health network was not sufficient to ensure timely access.

Statutory/Regulatory Reference(s): Rules 1300.67.2.2(d)(3), (g)(2)(C) and 1300.70(a)(1) and (3)

Supporting Documentation:

- Plan's Measurement Year (MY) 2021 *Timely Access Compliance Report*
- Plan's MY 2020 *Timely Access Compliance Report*
- Plan's MY 2019 *Timely Access Compliance Report*
- Plan policy *Access to Care Standards* (Revised March 9, 2021, efiling 20211304)
- Plan's Provider Survey Summary (2020, 2021)

Assessment: Each year, the Plan conducts a Provider Appointment Availability Survey (PAAS). The Plan uses a vendor to survey the Plan's provider networks to determine compliance with regulatory standards for appointment availability for both urgent and non-urgent appointments. The overall percentage of providers surveyed who could deliver an appointment within the time-elapsed standards is referred to as the "rate of compliance." The PAAS results are reported to the Department in the Plan's *Timely Access Compliance Report.*

Although recent amendments to Rule 1300.67.2.2 establish a timely access threshold rate of compliance below which a health plan must take corrective action, at the time of the BHI, there was not a required rate of compliance with time-elapsed standards in the Knox-Keene Act. While the Plan was required to report the percentage of providers who had an appointment that is compliant with the applicable wait time standard, the Department's only mechanism for evaluating the legal compliance of the reported rate of compliance was to review the Plan's PAAS results against the Plan's policies and procedures that establish the Plan's internal standard for taking corrective action.[7] These policies and procedures are submitted during a plan's licensure, either as part of the initial license application or via an amendment or material modification to the license.

[7] While the amendments were not in effect during the review period of the Plan's BHI, Rule 1300.67.2.2 was subsequently amended to require health plans to demonstrate a network is sufficient to provide enrollees timely access to health care services. To demonstrate each network is compliant, the network's PAAS results must meet or exceed a 70% threshold rate of compliance with the time elapsed standards set forth in Rule 1300.67.2.2(c)(5)(A)-(F), as calculated for the PAAS results, applicable to urgent and non-urgent appointments. The 70% threshold rate of compliance will be in effect for Measurement Year 2023 and will be applied to the Plan's data submitted to the Department on May 1, 2024.

During the review period of the Plan's BHI, the relevant PAAS results were reviewed against the Plan's internal standard of compliance and quality assurance monitoring policies. Rule 1300.67.2.2(g)(2)(C) requires health plans to identify any patterns of non-compliance and develop a "responsive investigation, determination and corrective action." Rule 1300.67.2.2(d)(3) requires health plans "implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance." Further, Rules 1300.70(a)(1) and (3) require a Plan's Quality Assurance program to address accessibility, availability and continuity of care as well as, "document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated."

The Plan's *Access to Care Standards* policy, filed with the Department, describes the Plan's methodology for determining noncompliance with required provider appointment wait time standards. The methodology defines a pattern of non-compliance "as a measure in which the rate of compliance for applicable providers is below 70%...." The policy further provides, "rates of compliance will be compared by network by the last two measurement years to determine if there was a compliance rate below 70% for two consecutive years, which would indicate a pattern of non-compliance by provider type." Additionally, the policy indicates that corrective action will be taken when non-compliance is identified.[8] In order to assess potential patterns of non-compliance, the Department reviewed the two most recent years of publicly available PAAS data. [9]

The Plan's PAAS data indicated that in several counties, its rate of compliance for urgent appointments with Psychiatrists and Non-Physician Mental Health providers fell below a 70% rate of compliance.[10] As part of the Provider Appointment Availability Survey, health plans submit a Results Template that includes the results of the health plan's survey for all provider types and appointment types. The Results Template includes a Network by Provider Survey Type tab that reports a weighted appointment rate across all counties in a network for each provider survey type. In MY 2019, the Plan's reported weighted rate of timely appointments (i.e., percent of appointments occurring within the appointment time-elapsed standards weighted by the number of

[8] The policy can be found in efiling 20211304. The policy states, "If monitoring activities result in findings of provider non-compliance with standards, the Quality Department will assess and discuss at Quality Council whether provider re-training, network expansion, corrective action, or targeted quality improvement projects would best resolve issues of timely access."

[9] At the time of the BHI, the two most recent years of available PAAS data were 2019 and 2020. Timely Access Data is published annually on the DMHC at https://www.dmhc.ca.gov/AbouttheDMHC/DMHCReports/PublicReports.aspx

[10] Although the Plan reports its service area as including only Contra Costa County, the Plan's PAAS data indicates some Plan psychiatrists are located in other counties, such as Alameda, San Francisco, San Mateo, Santa Clara, and Solano. Similarly, some Plan non-physician mental health providers are located in the same counties as the psychiatrists, as well as Sacramento and Yolo Counties.

providers within the network) across all counties for urgent care appointments with Non-Physician Mental Health Care Providers in the Plan's Community Provider Network (CPN) and Regional Medical Center (RMC) networks was 62%.[11] The Plan's MY 2019 weighted rate of timely urgent care appointments with Psychiatrists in the same networks were 59% and 60%, respectively. Similarly, in MY 2020, the reported weighted rate of timely appointments across all counties for urgent care appointments with Non-Physician Mental Health Care Providers in the Plan's CPN and RMC networks was 60% and the rate of timely appointments for urgent care appointments with Psychiatrists was 22% for the CPN network and 23% for the RMC network.

TABLE #1
CPN Network – Urgent Care Appointment Rates

	MY 2019	MY 2020
Non-Physician Mental Health Care Providers	62%	60%
Psychiatrists	59%	22%

TABLE #2
RMC Network – Urgent Care Appointment Rates

Provider Type	MY 2019	MY 2020
Non-Physician Mental Health Care Providers	62%	60%
Psychiatrists	60%	23%

Based on the MY 2019 and MY 2020 data, both of the Plan's networks indicate patterns of non-compliance under the Plan's policy. The Plan's MY 2020 *Timely Access Compliance Report* submission to the Department indicated that the cause of the decline in compliance rates between MY 2019 and MY 2020 for both networks was due to the Plan including inappropriate providers in its survey (e.g., hospital-based providers who do not offer appointments or tertiary providers who enrollees cannot readily access). The Plan's corrective action focused on updating the list of providers to be included in the survey. The Plan stated it believed it would have met its internal standards if these providers were not included in the survey. The analysis did not indicate whether these providers were included in both the MY 2019 and MY 2020 survey. If they were included in both measurement years, their inclusion does not explain the change in the rate of timely appointments. Overall, the Plan's MY 2020 submission did not indicate that any corrective action would be taken to improve actual compliance with appointment wait time standards.

[11] For MY 2019 and MY 2020, the Plan maintained a plan-to-plan arrangement with Kaiser. The cited rates of compliance do not account for providers made available to enrollees through the Kaiser plan-to-plan arrangement and only include the Plan's directly contracted network.

In its MY 2021 *Timely Access Compliance Report* submission to the Department, the Plan acknowledged patterns of non-compliance continued. Using its methodology for determining non-compliance, the Plan identified a pattern of non-compliance due to rates below 70% for two consecutive years for Psychiatrists. The Plan acknowledged that one of its largest provider groups, Comprehensive Psychiatric Services, had one of the lowest rates of compliance, particularly regarding urgent appointments. The Plan stated it would meet with the provider group to discuss root causes for non-compliance and "Depending on the outcome of this conversation, [Plan] actions *may* include a Corrective Action Plan that will be created by June 1, 2022…" [Emphasis added.] Based on the information in its *Timely Access Compliance Report*, the Plan did not provide evidence that it took *prompt* corrective action, as it did not take immediate action to resolve the concern with the provider group and did not commit to developing a corrective action plan. Overall, the Plan failed to demonstrate that it implemented a corrective action plan to improve the rates of compliance for those counties falling below 70% for more than two years, as required under its own policies and procedures and by Rules 1300.67.2.2(d)(3), (g)(2)(c) and 1300.70(a)(1) and (3).

The MY 2019 *Timely Access Compliance Report* submissions from the Plan also indicate a lack of effective action on behalf of the Plan to address timely access concerns. Prior to 2020, the Plan's Non-Compliance Methodology defined "pattern of non-compliance" as a rate of compliance below 50%. Even under this lower standard, the Plan identified patterns of non-compliance with access to non-urgent behavioral healthcare and non-urgent specialty care in its MY 2019 *Timely Access Compliance Report* submission, submitted to the Department on April 1, 2020.

Concerning access to behavioral health services, the Plan noted in its MY 2019 *Timely Access Compliance Report* that, "In order to provide better access, [the Plan] has contracted another provider network for these services. We will have two provider networks, greatly increasing the number of providers. This should lead to better compliance." The Plan's MY 2019 submission did not provide any additional details with respect to its behavioral health corrective action. It is unclear whether this corrective action included the addition of psychiatrists to the network or just non-physician mental health providers. The Plan's submission further indicated it offered higher rates to incentivize impacted specialist providers to contract with the Plan, but the Plan did not indicate whether it was offering this higher rate to psychiatrists. Therefore, the Plan's corrective action does not clearly address how it will improve the low rate of timely appointments to psychiatrists. It is evident from the MY 2020 and MY 2021 data that the Plan continued to fail to meet its own timely access thresholds for psychiatrists and failed to implement effective corrective measures, as required under Rule 1300.70(a)(1) and (3).

In addition to failing to take prompt and effective corrective action in response to the appointment availability survey results, the Plan also failed to take prompt corrective action when informed by providers that enrollees were not receiving timely behavioral health appointments. The 2020 Provider Survey summary indicated that 61.5% of the providers surveyed were "dissatisfied" or "very dissatisfied" with access to non-urgent

behavioral health care. Similarly, 51.3% of providers indicated they were “dissatisfied” or “very dissatisfied” in response to the question: “How satisfied are you with the behavioral health services provided for your members that you referred for non-urgent care?” Similarly low rates of provider satisfaction were identified in 2019, thereby placing the Plan on notice of high levels of dissatisfaction amongst its providers regarding access to behavioral health care.

The Plan’s Provider Timely Access Satisfaction Survey Methodology notes that satisfaction rates below 50% are a signal for concern; however, the methodology does not identify a procedure for addressing satisfaction rates below 50%. The Plan acknowledged the 2020 results stating, “The most pressing area for improvement seems to be urgent and non-urgent behavioral health services for both networks” however, the conclusion does not identify subsequent steps to follow up on these results. The Plan provided no indication it would take any corrective action to address the concerns raised in the provider satisfaction survey.

The timely access regulations are in place to ensure enrollees get the care that they need when they need it. Rule 1300.67.2.2(d)(2)(D) requires the Plan to evaluate the results of its timely access monitoring in conjunction with its quality assurance policies to improve access to care within its networks. In furtherance of these requirements, Rule 1300.70(a)(1) requires the Plan’s quality assurance program to both identify problems and take effective action to improve care where deficiencies are identified. Despite submitting the required components of the *Timely Access Compliance Report*, the Plan’s documents show a lack of prompt and effective corrective action in response to the timely access issues identified, as required by Rules 1300.67.2.2(d)(3) and 1300.70(a). Self-review and corrective action by the Plan are critical to ensuring substantive improvement in enrollee access to behavioral health services. The Plan’s most recent PAAS data and internal documentation indicate that enrollees seeking services from psychiatrists or non-physician mental health providers may be unable to obtain timely appointments.[12]

Conclusion: The Plan’s annual PAAS data indicates non-compliance with the Plan’s internal 70% standard of appointment availability, which required the Plan to implement prompt investigation and corrective action to ensure timely access. The data reflects rates of compliance below 70% for behavioral health providers for two years in both networks thereby indicating patterns of non-compliance as defined in the Plan’s policy. Review of Plan documents provided little evidence the Plan took any prompt corrective action as required by Rules 1300.67.2.2(g)(2)(C) and (d)(3) Additionally, the low rates of compliance for behavioral health providers over several years indicate that any corrective actions taken by the Plan’s quality assurance program to address

[12] The Final Report for the Plan’s 2019 Routine Survey was issued on February 6, 2020, and covered a review period of November 1, 2016 through October 31, 2018, which preceded the review period for the Plan’s BHI. However, provider access and availability is being reviewed as part of the Plan’s 2022 Routine Survey.

deficiencies were not effective, as required under Rule 1300.70(a)(1). The Department therefore finds the Plan out of compliance with these regulatory requirements.

Subsequent to the completion of the Plan's BHI, Rule 1300.67.2.2 was amended to require health plans to demonstrate a network is sufficient to provide enrollees timely access to health care services. To demonstrate each network is compliant, the network's PAAS results must meet or exceed a 70% threshold rate of compliance standard with the time elapsed standards set forth in Rule 1300.67.2.2(c)(5)(A)-(F), as calculated for the PAAS results, for both urgent and non-urgent appointments. A health plan must submit a corrective action plan if it fails to meet the threshold rate of compliance for urgent or non-urgent appointments in a single measurement year. While not applicable to this BHI, the 70% threshold rates of compliance will be in effect for Measurement Year 2023 and will be applied to the Plan's data submitted to the Department on May 1, 2024.

#2: <u>The Plan failed to ensure the waiting time for an enrollee to speak by telephone with a plan customer service representative did not exceed 10 minutes.</u>

Statutory/Regulatory Reference(s): Section 1367(g); Rules 1300.67.2.2(c)(10), 1300.67.3(a)(2)

Supporting Documentation:

- Plan document *BHIAA 1_11 QC Report.xlxs* (*QC Report*)
- Plan policy *Quality Monitoring of the Member Services Department, Policy # MS 8.005* (revised June 2016)
- Plan document *Phone Performance Review Form v6* (undated)
- Plan document *Member Services Training Curriculum*, Policy # MS8.006 (reviewed 8/2021)

Assessment: 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 requested the Plan provide copies of customer service training policies and procedures, and documents addressing how the Plan monitors customer service operations to identify and correct problems enrollees may face navigating the customer service process when requesting behavioral health services. The Department also requested the Plan provide copies of behavioral health performance reports regarding call statistics. Items included in such reports might include speed to answer, call resolution reports (issue resolved on first call), repeat caller reports, call quality reports including accuracy of information and completeness of information provided, customer satisfaction surveys, and call drop reports for excessive hold times. In response, the Plan provided its *Quality Monitoring of the Member Services Department, Policy # MS 8.005* (*Quality Monitoring* policy), an Excel spreadsheet that provided customer service

call data (the QC Report) and the Plan's *Phone Performance Review Form v6*. The Plan also provided its *Member Services Training Curriculum* policy.

The *Member Services Training Curriculum* policy states the member services training curriculum "will include specific information about the Health Plan's product lines, e.g., Medi-Cal, as well as modules which instruct Counselors in skills appropriate to the position such as listening skills and evaluation skills to determine which calls warrant transfer to the Advice Nurse, etc." The policy does not address objective measures of performance such as speed to answer.

The stated purpose in the Plan's *Quality Monitoring* policy is to "assure that the [Plan] Member Services Unit is complying with all of the requirements of the Health Plan and applicable regulations." The policy also states the Plan "is responsible for verifying the accuracy and timeliness of all requirements handled by the Member Services Department. The Member Services Manager will implement procedures consistent with assuring that all requirements are met." Among other responsibilities, the *Quality Monitoring* policy states the Member Services Manager will generate quarterly reports regarding the operations of the Member Services phone systems to include data such as number of daily calls, average time to answer, longest wait and call abandonment rates.

The Plan's *Phone Performance Review Form v6* (Performance Review Form) is a form used to evaluate the performance of customer service staff. The form includes nine questions for which the evaluator checks either a "yes" or "no" box. The questions ask about whether the customer service staff greeted the caller, checked eligibility and assisted the caller with their request, among other things. However, neither the *Quality Monitoring* policy nor the Performance Review Form address or evaluate performance standards such as the 10-minute wait time required by Rule 1300.67.2.2(c)(10), or any other Plan standards for speed to answer, abandonment rates or accuracy of information provided to callers.

The Plan's QC Report spreadsheet included fields for number of incoming and outbound calls, number of inbound and outbound calls per 1,000 members, average answer time plus call back time, and abandonment rate. The QC Report included data for all four quarters of both 2019 and 2020 and the first two quarters of 2021.[13] The QC Report set a standard of 10 minutes for average answer time plus call back time, and a standard of 5% and goal of 8% for abandonment rates. However, these standards were not included in any of the provided policies or procedures, nor were these standards applied in the Performance Review Form used to evaluate customer service staff performance. Additionally, it is not clear, with respect to call abandonment rates, what the difference is between the stated 5% standard and the 8% goal.

[13] The Plan provided final data for all four quarters of 2019, and pending data for Q2 2021. However, the provided data for Q1 2019 and Q2 2021 was excluded from review and inclusion in this Report as that data was outside the BHI review period of April 1, 2019, through March 31, 2021.

As summarized in Table #3 below, the data in the QC Report demonstrates the Plan exceeded the required 10-minute wait time standard during four of the eight quarters reviewed between Q2 2019 and Q1 2021, in violation of Rule 1300.67.2.2(c)(10). Of significance was the average wait time for Q1 2021, which was 2 hours and 45 minutes, although the total number of incoming and outbound calls was not significantly different from the number of calls in 2020. The Plan's data also shows the call abandonment rates ranged from 15% to 21% for six of the same eight quarters and exceeded both the stated 5% standard and 8% goal in seven of the eight quarters.

In addition to the excessive wait times and high call abandonment rates, the Plan's processes require customer service staff to refer all calls involving behavioral health requests and services to the Plan's one utilization management behavioral health nurse. The Plan's Desk Procedures document for behavioral health services states, in part: Mental Health Calls:

- For Commercial:
    - Explain to the members that mental health is covered.
    - Explain to the member that they need to speak to the [Plan] Mental Health nurse
    - Transfer members to [Plan] Mental Health nurse line (925) 313-[xxxx].

Rule 1300.67.2.2(c)(10) requires plans to ensure not only that enrollee wait time does not exceed 10 minutes to speak with a customer service representative, but also that the customer service representative is "knowledgeable and competent regarding the enrollee's questions and concerns." By requiring customer service staff to transfer all behavioral health related calls to the utilization management behavioral health nurse, and by failing to ensure its customer service staff are knowledgeable and competent to address enrollee questions and concerns, the Plan is in further violation of Rule 1300.67.2.2(c)(10). [14]

Furthermore, reliance on one utilization management behavioral health nurse to handle all calls related to behavioral health services indicates the Plan does not have sufficient administrative capacity to ensure the provision of services to enrollees and effective handling of enrollee calls as required by Section 1367(g) and Rule 1300.67.3(a)(2). These provisions require the Plan to furnish services in a reasonable and efficient manner and provide administrative services that are effective in conducting the Plan's business. Answering telephone calls from enrollees requesting assistance with behavioral health services is a step in providing covered services to enrollees. The Plan's process of requiring customer service staff to transfer all calls related to behavioral health services to the utilization management nurse, together with the

[14] The Desk Procedure refers only to "mental health" but does not mention handling of calls pertaining to "substance use disorder." However, the Plan made clear during interviews that calls pertaining to substance use disorder received by customer service staff are also referred to the Plan's UM behavioral health nurse for review.

average call time data for Q3 2020 and Q1 2021 demonstrate the Plan's administrative capacity does not meet the statutory and regulatory requirements.

TABLE #3
Member Services Call Statistics

	2019			2020				2021
Indicator	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Number of incoming and outbound calls	32,393	31,631	29,666	34,141	26,640	35,321	33,925	34,084
Average answer time plus call back time in minutes	3:37	3:57	18:11	5:13	8:24	28:38	37:00	2:45:00
Abandonment rate	*5%*	*19%*	*15%*	*21%*	*11%*	*18%*	*16%*	*19%*

Conclusion: Based on review of Plan documents and data, the Department finds the Plan out of compliance with the 10-minute wait time standard in Rule 1300.67.2.2(c)(10) to speak with a customer service representative knowledgeable and competent regarding the enrollee's questions and concerns.[15] Additionally, referring all behavioral health calls to one utilization management nurse, together with call data demonstrates the Plan failed to maintain sufficient administrative capacity in violation of Section 1367(g) and Rule 1300.67.3(a)(2).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#3: The Plan failed to consistently notify the requesting provider of authorization decisions within 24 hours of making the decision.

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

Supporting Documentation:

- 68 Prior Authorization Utilization Management files (April 1, 2019 – March 31, 2021)

[15] Upon request by the Department, the Plan should be prepared to provide a description of the Plan's customer service practices as they pertain to enrollee inquiries and issues involving medical/surgical services, and an explanation of how those practices differ from the customer service practices described in this Knox-Keene violation #2 pertaining to behavioral health services.

Assessment: Health plans are required to communicate utilization review decisions to requesting providers within 24 hours of making the decision when the request is made prior to or concurrent with the provision of services. [16]

The Department reviewed a random sample of 68 standard prior authorization utilization management files from a universe of 3,020 files for the investigation period. The Department determined in 17 instances[17] (25% of the files reviewed), the Plan failed to notify the requesting provider within 24 hours of making the authorization decision.

TABLE #4
Timeliness of Notification of Utilization Management Decisions

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Utilization Management Authorization Files	68	Notification of approval determination to the provider within 24 hours of the decision	51 (75%)	17 (25%)

Conclusion: Section 1367.01(h)(3) requires health plans to notify requesting providers of prior authorization and concurrent review utilization management authorization decision within 24 hours of the decision. Based on review of the Plan's utilization management files, the Department found the Plan did not consistently provide timely notification in violation of Section 1367.01(h)(3).

#4: <u>The Plan is operating at variance with its filed utilization management policy.</u>

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

Supporting Documentation:

- Plan policy *Utilization Review Criteria and Guidelines* #UM 15.002 (eFiled August 13, 2018)
- 68 Prior Authorization Utilization Management files (April 1, 2019 – March 31, 2021)
- Plan PDF provider directories

Assessment: Health plans are subject to disciplinary action if it is determined, among other things, the plan is operating at variance with documents filed with the Department as part of the plan's licensure or with filed amendments or material modification filings.[18]

[16] Section 1367.01(h)(3)
[17] File #10, File #12, File #13, File #15, File #21, File #31, File #33, File #42, File #43, File #51, File #55, File #57 File #58, File #61, File #65, File #66 and File #68
[18] Sections 1386(b)(1), 1351, 1352.

Included among the types of documents required to be filed are utilization management policies and procedures.[19]

As required by Section 1352(a), the Plan filed an amendment with the Department in August 2018[20] that included revisions to the Plan's *Utilization Review Criteria and Guidelines* policy.[21] The revised policy states in part:

> The following Mental Health (MH) and Substance Use Disorder (SUD) Services require a prior authorization (PA):
>
> - MH outpatient monitoring of drug therapy beyond 2 visits: This type of service is provided by psychiatrists. CCHP provides psychiatric medication consultation, evaluation or care and follow up for psychiatrist medication monitoring.
> - MH outpatient services beyond 2 visits: psychotherapy, SUD outpatient services and MH individual and group treatment.

Consistent with the Plan's *Utilization Review Criteria and Guidelines* policy, prior authorization is not required for the initial two visits of outpatient medication monitoring or psychotherapy services with contracted providers.[22]

The Department reviewed PDF copies of the Plan's provider directories available to enrollees on the Plan's website.[23] A note at the bottom of page 22 of the medical/surgical PDF provider directory states:

> Note - For Behavioral Health Counseling Services: For all other Members (non Medi-Cal), [to] access outpatient mental health services, please call Mental Health Authorizations at 1-877-661-6230 (press 4).

At the top of the first page of the Plan's PDF Mental Health Provider Directory, under the heading "Introduction" it states:

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[19] Sections 1351(m), 1367.01(b), 1367.01(j).
[20] See eFiling #20182200.
[21] In connection with the BHIs, the Plan submitted the *Utilization Review Criteria and Guidelines* policy that includes a policy revision date of July 20, 2018 (and review dates of January 2019 and January 2021). However, this version of the policy submitted for the BHIs, unlike the version filed with the Department on August 13,2018, states the outpatient mental health drug monitoring and psychotherapy services require authorization after one initial visit and seven follow up visits, rather than after two visits. In evaluating whether a plan is operating at variance with a policy and procedure under Section 1386(b)(1), the Department must consider the version(s) on file with the Department. The Plan should evaluate whether the version of the policy submitted for the BHIs should be filed with the Department pursuant to Section 1352. However, under either version of the policy, Plan files demonstrated operations inconsistent with prior authorization requirements stated in either policy.
[22] Upon request by the Department, the Plan should be prepared to provide a description of the Plan's process involving prior authorization as applied to medical/surgical outpatient monitoring of drug therapy and outpatient services, and explain the differences between the Plan's prior authorization processes as they apply to behavioral health and medical/surgical services.
[23] www.cchealth.org/healthplan

> The following is a comprehensive list of providers for the Contra Costa Mental Health Plan (CCMHP). *Please be aware that authorizations for treatment must be made by first calling the Plan's Access Line telephone number at 1-888-678-7277*. Providers will not accept direct referrals from beneficiaries. All phone calls made directly to providers will be referred to the Plan's Access Line for an appropriate referral. Interpreter services are available through all organizational providers. Call toll-free 1-888-678-7277 to learn which providers are not accepting new beneficiaries." (Italics added for emphasis)

According to the PDF versions of the provider directories, all behavioral health services require prior authorization, instructing enrollees to call the Plan to obtain authorization. This instruction is contrary to the requirements in the Plan's *Utilization Review Criteria and Guidelines* policy.

The Department selected and reviewed 68 prior authorization utilization management case files. In at least 10 of the first 30 files reviewed, prior authorization was sought for outpatient behavioral health services when authorization was not required because the services included the first two visits of psychotherapy or medication management.[24] Moreover, the utilization management data provided by the Plan (Log A data and other provided utilization management information) indicate that virtually all psychotherapy services provided to enrollees during the review period underwent utilization management review. Because the Plan required and conducted utilization review for services that, according to the Plan's policy did not require utilization review, the Department found the Plan operating at variance with its *Utilization Review Criteria and Guidelines* policy.

Conclusion: The Plan's *Utilization Review Criteria and Guidelines* policy, on file with the Department, places limits on prior authorization requirements for certain outpatient behavioral health services. Contrary to the policy, the Plan's PDF provider directories inform enrollees that prior authorization is necessary for services that do not require utilization review. File review confirmed the Plan requires prior authorization for services not identified in the *Utilization Review Criteria and Guidelines* policy as requiring prior authorization. Accordingly, the Department finds the Plan is operating at variance with this policy in violation of Section 1386(b)(1).

QUALITY ASSURANCE

#5: The Plan failed to establish and implement a quality assurance process that assesses and evaluates compliance with utilization management requirements.

[24] See File #s 6, 8, 14, 19, 21, 22, 24, 25, 27 and 29, which all involved CPT code 99205, a code for office visit for evaluation and management of a new patient. Even under the Plan's updated policy submitted for the BHIs, the Plan's files would conflict with policy requirements requiring authorization after seven follow up visits.

Statutory/Regulatory Reference(s): Rules 1300.70(a)(3), 1300.70(c)

Supporting Documentation:
- Plan response to BHI Questionnaire

Assessment: The Department requested the Plan provide utilization management reports specific to behavioral health services to demonstrate the Plan is reviewing behavioral health services for accessibility, availability and continuity of care. In response, the Plan stated it does not generate such reports specific to behavioral health services. During the on-site interview held on November 8, 2021, the Plan's Chief Medical Officer confirmed that no behavioral health utilization reports were generated during the investigation review period. While the Plan stated it broadly reviews data related to over and under-utilization metrics, it provided no evidence of monitoring or evaluation of key metrics for utilization of behavioral health services, such as admissions per thousand, days per thousand, or admissions by diagnostic categories or groupings.

Health plans are required to maintain quality assurance programs that monitor whether the provision and utilization of services meets professionally recognized standards of practice.[25] Plans must also design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost.[26]

The Plan indicated its behavioral health reports are used primarily for actuarial purposes but was unable to demonstrate that such reports are regularly reviewed by clinical leadership at the Plan. The Plan's December 10, 2020 Quality Council meeting minutes included turnaround times for behavioral health service requests, but no other utilization data was recorded as being provided to or reviewed by the Quality Council. Without reviewing specific behavioral health utilization data, the Plan is unable to regularly assess utilization of services or monitor whether utilization meets professionally recognized standards of practice. Accordingly, the Department finds the Plan out of compliance with Rules 1300.70(a)(3) and 1300.70(c).[27]

Conclusion: A health plan's quality assurance program must monitor utilization of services and performance of health care personnel to ensure services meet professionally recognized standards of practice. Based on Plan documentation and statements made by Plan representatives, the Department found the Plan out of compliance with Rules 1300.70(a)(3) and 1300.70(c).

[25] See Rule 1300.70(a)(3).
[26] See Rule 1300.70(c).
[27] Upon request by the Department, the Plan should be prepared to provide a description of the Plan's process for monitoring of under- and over-utilization for medical/surgical services, including utilization reports generated for medical/surgical services, and explain the differences between the Plan's processes as they apply to behavioral health and medical/surgical services.

GRIEVANCES AND APPEALS

#6: Failure of customer service to identify all grievances.

Statutory/Regulatory Reference(s): Rule 1300.68(a)(1)

Supporting Documentation:

- 50 customer service inquiry files (April 1, 2019 – March 31, 2021)

Assessment: Health plans must have procedures to ensure grievances are reviewed and resolved timely. A grievance is defined as "a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative."[28]

The Department reviewed 50 behavioral health inquiry files. Of the 50 files, four[29] involved expressions of dissatisfaction: two concerning provider referral problems and the other two concerning Plan operations.

Inquiry File #15: An enrollee's parent called the Plan in mid-August 2019 stating his child's provider should have submitted a referral request in June and as of yet, the parent had yet to be contacted or receive any update about the services. The Plan's customer service representative noted there was no referral on file and instructed the enrollee's parent to "follow up with the provider's office" and closed the inquiry as resolved.

Inquiry File #30: An enrollee called to request mental health services. The enrollee noted during the call that they called two weeks prior for the same request and was referred to the Plan's utilization management behavioral health nurse. The customer service representative documented in the notes: "Due to multiple attempts by member to obtain the sensitive services, I sent an email to [the utilization management behavioral health nurse] to follow up with the member's reported attempts to contact." The inquiry was closed within five minutes as resolved.

Inquiry File #33: An enrollee sought to obtain an authorization or referral for a psychiatrist. She complained of being referred back and forth between the Plan and the Contra Costa County Access Line.[30] The customer service representative confirmed the Access Line is not how the enrollee would obtain a referral and discovered the enrollee's primary care physician had been submitting the request to the Access Line. The customer service representative instructed the enrollee to contact her primary care physician and ask the physician to submit the request to the Plan. The inquiry was closed 26 minutes after the call was received.

[28] Rule 1300.68(a)(1).
[29] Inquiry File #15, File #30, File #33 and File #42.
[30] The Access Line is a 24-hour telephone number that individuals can call to find resources for mental health and substance use services.

Inquiry File #42: An enrollee's parent called the Plan to state his son was prescribed psychiatric medication during an emergency room visit, but the enrollee was having an adverse reaction. The parent contacted the enrollee's primary care physician, but was told the physician could not change or adjust the medication until the enrollee sees a psychiatrist. When the parent attempted to make an appointment with a psychiatrist by calling the Access Line, he was referred back to the Plan. The parent stated he felt he was "getting the run around." The customer service representative told the parent he would need to speak with the Plan's utilization management behavioral health nurse, but that the customer service representative already left a message for the nurse, so the parent would need to wait for the nurse to return the call to the parent. The inquiry was closed within two hours after the call was received.

Although the inquiries above involved expressions of dissatisfaction with referral problems and difficulties in obtaining services, none of the four inquiries were identified or handled by the Plan as grievances, in violation of Rule 1300.68(a).

Conclusion: The Plan's customer service representatives failed to identify enrollee calls as grievances although they involved expressions of dissatisfaction with providers or the Plan. Failure to identify and process grievances hinders a health plan's ability to accurately track and trend grievances, identify patterns and timely correct problems. Additionally, enrollees are denied certain rights, such as adequate consideration of their grievance and the receipt of acknowledgement and/or resolution letters describing any investigation and outcome of the grievance, and appeals rights, when applicable. The Department therefore determined the Plan was out of compliance with Rule 1300.68(a).

CLAIMS SUBMISSION AND PAYMENT

#7: Failure to timely pay claims.

Statutory/Regulatory Reference(s): Section 1371(a)(1)

Supporting Documentation:

- 54 uncontested paid claims files (April 1, 2019 – March 31, 2021)

Assessment: If a health plan is a health maintenance organization, as is Contra Costa Health Plan, it is required to reimburse claims as soon as practicable, but no later than, 45 working days after receipt of the claim.[31]

The Department reviewed a random sample of 54 paid claim files for behavioral health services from a universe of 9,980 files for the review period. All 54 claims were uncontested claims. The Department determined in seven files[32] (13%) the Plan did not pay the claim within 45 working days after receipt. The days to pay these seven claims

[31] Section 1371(a)(1).
[32] File #3, File #21-23, File #25, File #44-45

ranged from 84 days to 448 days with the average days to pay being 237 days. The Plan is therefore out of compliance with Section 1371(a)(1).

TABLE #5
Timeliness of Claim Payments

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Uncontested paid claims for behavioral health service	54	Payment no later than 45 working days after receipt of the claim by the health care service plan	47 (87%)	7 (13%)

Conclusion: Based on review of uncontested behavioral health claims files, the Department found the Plan failed to consistently pay claims on a timely basis, in violation of Section 1371(a)(1).

CULTURAL COMPETENCY, HEALTH EQUITY AND LANGUAGE ASSISTANCE

#8: 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:
- Plan policy *Training on Cultural Competency and SPD awareness Policy # CL 20.007* (September 2021)
- Plan document *BHT Unit Policies and Procedures* (undated)

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.

Rule 1300.67.04(c)(3)(D) requires plans to have a system in place for training its staff as follows:

> 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.

The Department reviewed the Plan's *Training on Cultural Competency and SPD awareness Policy # CL 20.007*. The policy describes the means through which the Plan provides Plan staff with educational and training opportunities, including, for example, newsletters and special bulletins, staff meetings, the Plan's website, facility site reviews and provider manuals. The policy further states cultural and linguistic issues are addressed through formal trainings, employee orientation, interpreter training, clinical trainings and cultural seminars. Sample curriculum topics are listed in the policy as they pertain to Plan staff and providers. However, the Plan provided little documentation evidencing implementation of most of these methods and training opportunities. The Plan provided no copies of newsletters or bulletins, annual reports or seminar agendas with training dates and lists of attendees.

The Plan also provided two documents labeled *BHT[33] Unit Policies and Procedures.* Each document consisted of a single page, with one document listing contact information for community resource, and the other document providing information about Contra Costa Health Plan's Cultural Competence Policy, Cultural Competence Procedures, Linguistic Services Policy and Linguistic Services Procedures. This document stated: "All BHT staff will complete any and all cultural competency trainings required by the health plan, to include annual updates" along with an embedded link to training documents and training resources located on the Plan's website. The linked webpage presented several training resources under the categories of SPD Training (Seniors and Persons with Disabilities) Information for Health Care Providers, Cultural Competency Training for Health Care Providers, and Limited English Proficient Patients. However, the Plan presented no information or evidence that it required Plan staff who have routine contact with Limited English Proficient enrollees to take any of the trainings shown on the Plan's website. Furthermore, the Plan provided no evidence or documents to demonstrate it tracks which Plan staff take and complete the trainings. The Plan provided no other documentation evidencing training for Plan staff regarding issues of cultural competency relevant to delivery of health care interpretation services. Accordingly, the Plan was not able to demonstrate it provides language assistance program training to Plan staff as required by Rule 1300.67.04(c)(3)(D).

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

[33] Behavioral Health Treatment.

SECTION II: SUMMARY OF BARRIER 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 does not have a process for providing integrated behavioral health services.

Summary: The Plan does not have a policy or procedure that addresses integrated behavioral health services. Behavioral health integration is an approach to delivering mental health and substance use disorder care and treatment that involves primary care and behavioral health providers working together using a team-based approach. Additionally, when asked to provide procedure codes for services covered by the Plan, the Plan provided no procedure codes related to integrated behavioral health services.

#2: The Plan conducts utilization management for behavioral health services that are not subject to prior authorization, which may delay access to services.

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 utilization management policy filed with the Department. Based on the Plan's utilization management policy, no utilization management review by the Plan was needed for certain behavioral health services. Enrollees who need those services should be able to make appointments directly with providers. However, because the Plan conducted utilization review for those services, the enrollees' ability to obtain those services was delayed by the amount of time taken to conduct unnecessary utilization review. These utilization management delays create barriers to timely access.

#3: The Plan does not cover Opioid Use Disorder treatment in an office-based or telehealth setting.

Summary: When asked to provide procedure codes the Plan utilizes for covered services, the Plan provided no procedure codes used for Opioid Use Disorder treatment rendered in a telehealth or office-based setting. These codes address services provided during the initial month of treatment and include intake processes, development of a treatment plan, care coordination and individual and group therapy (at least 70 minutes in the first calendar month). Other codes address care provided during subsequent

months, as well as additional coordination, individual therapy and group therapy when additional care is required.

Because office-based settings are generally more accessible to enrollees and hold less social stigma as compared to formal treatment program settings, failure to use these codes for Office Based Opioid Treatment services creates a barrier that unnecessarily limits the locations where opioid use disorder treatment can be provided.

#4: 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 and gender identity, income level and geographic location.

Summary: As discussed in Knox-Keene violation #8 above, the Plan provided little evidence that Plan staff received cultural competency training. Providers who complete the PowerPoint cultural competency training titled *Cultural Competency Training for Healthcare Providers: Connecting with your patients* available on the Plan's website can click a link to self-attest that they completed the training, although the Plan does not independently verify completion of the training. Once a provider self-attests to completing the training, the provider is recognized in the Plan's provider directory as "Trained in Cultural Competency." Lack of training for Plan staff and lack of oversight and assessment of the effectiveness of training can create barriers for enrollees who would benefit from culturally competent Plan practices and providers.

Plan documents stated the Plan's Behavioral Health Treatment Unit adopted the Cultural Competence Plan Requirements of Contra Costa Mental Health as described in a document titled *Cultural Competence Plan Update.* The *Cultural Competence Plan Update* describes the mental health services and programs provided throughout Contra Costa County's public mental health system and describes strategies for reducing disparities. However, the Plan provided no documents showing the actions the Plan took in connection with its adoption of these requirements.

Finally, the Department requested the Plan produce documents that address how the Plan identifies disparities experienced by enrollees when accessing behavioral health services, including age, race, culture, ethnicity, sexual orientation and gender identity, income level and geographic location. The Plan's response included three graphs that demonstrated its processes for identifying disparities is limited to (1) depression screenings comparing persons who identify with their legal sex with persons with a gender identity different from what was assigned at birth, and (2) developmental screening disparities between males and females. Because the Plan does not identify other persons or groups of persons subject to disparities, the Department found the Plan's process for identifying disparities is inadequate and creates barriers for individuals experiencing disparities other than those identified by the Plan.

The Plan has not demonstrated that 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 Plan's inability to know whether it is meeting the cultural needs of its population goes beyond simply not knowing whether it has a provider mix reflective of enrollee demographics. The Plan's provider directory identifies providers as having completed cultural competence training and being culturally competent solely on the basis of the provider's self-attestation of completion of a single online training module that is limited in scope. Thus, the Plan's provider directory may be misleading enrollees to believe that cultural competency exists where it does not.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified eight 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 submitted by the Plan, will be posted to the **Department's website**.

APPENDIX A

APPENDIX A. INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
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 Program Specialist II
Jamie Gordon	Health Program Specialist II
Christian Jacobs	Health Program 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 AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CONTRA COSTA HEALTH PLAN	
Sharron Mackey, M.H.S., M.P.A.	Chief Executive Office
Angela Choy	Chief Operations Officer
Dennis Hsieh MD, JD	Medical Director
Linda Copeland, MD	Consultant
Frank Lee, JD	Director of Compliance & Government Relations
Terri Lieder, MPA, CPCS,CPMSM	Director of Provider Relations and Credentialing
Tammy Fisher	UM Director
Belkys Teutle	Manager of Member Services
Nicole Branning	QM Manager
Joyce Al-Islam, RN	UM Manager
Robin Brevard, RN	UM Nurse
Robert Auman	Project Manager
Otilia Tiutin, PhD, DNM	C&L Services Manager
Wendy Mascitto	Program Manager
Shailesh Acharya	Program Manager
Alec Nielsen	Planner/Evaluator
Claudia Ortega	MS Counselor
Cheryl Armstrong	MS Counselor
DELEGATE STAFF INTERVIEWED FROM: PerformRx	
Joseph Cardinelli, PharmD.	Pharmacy Director

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries	50	964315 954819 955091 954139 950896 950028 948688 948467 946740 945752 942442 940429 936189 935030 934700 933938 932682 932389 925675 925027 924922 923853 922964 921275 919280 916093 915611 915453 915299 914952 1006795 972724 891414 1006191 908001 1017505 913554 1020555 991344 961754

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries (continued)		885567 1003698 900943 1007332 988587 888362 997529 970331 959119 884936
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Denied Claims	29	10114781 10451287 10609478 12074709 10907162 9710119 13059372 12167706 11291872 9794441 11509274 10908095 13862988 11703328 14134183 13854877 14097735 14097734 14134182 13854876 10951713 10745174 10702377 10391787 9873013 14097733 14566809 11116148 12755185

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims	31	10517450 10595660 13358109 11632881 12997924 11108584 12421278 13514137 12726583 10414450 10870617 10755229 10787063 10755631 10771380 10754969 12508807 12670370 10093809 13744370 13423247 12997844 13513267 12754391 13137701 13595191 9774387 11527372 12418987 13339001 12797344
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Grievances	1	978845

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management	69	2785888 2711011 2499275 2266206 2600637 2352785 2645486 2581651 2638910 2682601 2785355 2255863 2280596 2449569 2250457 2829820 2291540 2377595 2550258 2318910 2716994 2257215 2708050 2375033 2606114 2260426 2669112 2763300 2402508 2336733 2497738 2712278 2298957 2777576 2224327 2418784 2705376 2439207 2439198 2439191 2446351 2328327 2535238 2538171 2501275

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management (continued)		2203164 2780015 2840965 2343668 2308564 2876659 2485358 2445131 2356403 2875812 2638916 2682624 2775455 2266219 2606384 2592630 2481288 2571681 2818918 2420960 2725089 2197374 2264403 2421395
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Enrollee Requests for Out of Network Behavioral Health Provider	10	2212517 2237144 2251298 2499427 2619655 2645793 2706085 2817696 2724362 2830256

CONTRA COSTA HEALTH PLAN CORRECTIVE ACTION PLAN RESPONSE

595 Center Avenue Suite 100 Martinez, CA 94533 | Main Number: (925) 313-6000 | Main Fax: (925) 313-6580 cchealth.org

Behavioral Health Investigation Report
Contra Costa Medical Services DBA
Contra Costa Health Plan
May 23, 2023

CATEGORY

Knox Keene Deficiency - Finding Number 1.1

DEFICIENCY

The Plan failed to implement prompt corrective action when provider appointment monitoring (PAAS) revealed the behavioral health network was not sufficient to ensure timely access.

CORRECTIVE ACTION SUMMARY

CCHP is compliant with its policy and procedure for establishing corrective actions related to timely access appointment monitoring. CCHP defines non-compliance as being under the threshold for "at least two years in a row." Therefore, no providers were deemed non-compliant until MY21, when a provider demonstrated a pattern of non-compliance for all of 2020 and 2021. In that instance, CCHP did launch a corrective action. Please see "1.1 NC Patterns MY 21."

Additionally, CCHP has active reports to monitor for PAAS failures and CAP provider accordingly. For example, the "1.1 NC Patterns MY21" report shows that CCHP Psychiatrists did not comply with appointment availability for two (2) years in a row, resulting in a pattern of non-compliance. An investigation was conducted, see: "1.1 Follow TARP NC." In that instance, CCHP responded to the findings by implementing a corrective action including expanding access to psychiatric care by increasing the number of contracted psychiatric providers. Three (3) psychiatrists were added to the network in 2020, seven (7) in 2021, three (3) in 2022, and two (2) have been added in 2023 with an additional eight (8) projected to approved by 2023. Please see the attached report for further details.

REQUIRED ACTION

CCHP believes it is compliant with the noted provision. Accordingly, CCHP has submitted a factual inconsistency argument to DMHC on June 7, 2023. However, CCHP will continue to closely monitor the PAAS survey and take appropriate action according to the results.

CORRECTIVE ACTION PLAN
Please see the above sections.

Implementation: June 22, 2023

Management Position Responsible: Director of Quality Management

SUPPORTING INFORMATION

Supporting Material	Explanation of Support
1.1 NC Patterns MY21, 1.1 NC Patterns MY20, 1.1 NC Patterns MY19	The chart displays a breakdown of psychiatrists and non-physician mental health by network (CPN/RMC).
1.1 Follow TARP NC	An investigation was conducted, see: "1.1 Follow TARP NC" Corrective Action was completed with Comprehensive Psychiatric Services, which is detailed in the above report.
1.1 MY20 14101 TACSM	Defines CCHP's standard for non-compliance.

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Behavioral Health Investigation Report
Contra Costa Medical Services DBA
Contra Costa Health Plan
May 23, 2023

CATEGORY

Knox Keene Deficiency - Finding Number 1.2

DEFICIENCY

The Plan failed to ensure the waiting time for an enrollee to speak by telephone with a plan customer service representative did not exceed ten (10) minutes.

CORRECTIVE ACTION SUMMARY

Since the DMHC audit in 2021, the Member Services Department had:

- Revised the Policy & Procedure, MS 8.005 Quality Monitoring of Member Services, which now includes the DMHC 10 minute wait time standard.
- Updated the desk procedure for callers requesting assistance for Mental Health and Substance Use Services. (See: MH Desk Procedures Benefit Grid 2023.04.pdf) Commercial Plan callers no longer get transferred to one UM Nurse when they are seeking providers. Instead, the Member Services Representative answering the call will assist the member directly.

	2022			
	Q1	Q2	Q3	Q4
TOTAL MEMBERS	228,809	234,956	242,482	247,793
# Inbound & Outbound Calls	39,467	35,709	39,569	36,308
# of Inbound & Outbound Calls/1000 members	172.5	152	163.2	146.5
Average answer time plus call back time (seconds) (Standard: 10 minutes)	0:58:57	0:33:06	0:15:15	0:10:13
Abandonment Rate (Standard: 5% ; Goal: 8%)	22%	16%	11%	9%
Average Handle Time	0:06:21	0:06:29	0:06:37	0:06:26

REQUIRED ACTION

CCHP needs to continue cutting call wait times. Please see the below Corrective Action Plan.

CORRECTIVE ACTION PLAN

The Member Services Department will also be reducing CCHP's call wait times further by hiring and training additional Member Services Representatives as well as leveraging technology to enable members to self-service common requests, such as making PCP changes. Given a significant volume of calls are on these topics, CCHP anticipates this will significantly cut call volume and therefore call wait times.

Implementation: June 22, 2023

Management Position Responsible: Director of Member Services

SUPPORTING INFORMATION

Supporting Material	Explanation of Support
1.2 MH Desk Proce 23.04 1.2 MS 8.005 22-09	These attachments show CCHP's continued requirement to maintain compliance with the relevant provisions.

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CATEGORY

Knox Keene Deficiency - Finding Number 1.3

DEFICIENCY

The Plan failed to consistently notify the requesting provider of authorization decisions within 24 hours of making the decision.

CORRECTIVE ACTION SUMMARY

The Behavioral Health Department is responsible for processing the authorizations at issue. BHD is aware of the shortcomings since the audit and has implemented process improvement plans since that time to improve the TAT of its referral notifications. BHD reports on its TAT findings to Quality Council as well as UM Committee. Recent reports show greater than 99% compliance of TAT. Please see supporting documentation.

REQUIRED ACTION

CCHP is required to communicate utilization review decisions to requesting providers within 24 hours of making the decision when the request is made prior to or concurrent with the provision of services.

CORRECTIVE ACTION PLAN

CCHP will continue to ensure its TAT are compliant, including notification of the requesting provider of authorization decisions within 24 hours of making the decision.

Implementation: June 22, 2023

Management Position Responsible: Director of Behavioral Health Department

SUPPORTING INFORMATION

Supporting Materials	Explanation of Support
1.3 QC Min wBH 22-09; 1.3 QC Min wBH 22-11; 1.3 QC Min wBH 23-02; 1.3 UM CMin 07-22-05-23.	Attachments show that when reported, BHD TAT of authorizations are >99%, which includes consistently notifying the requesting provider of authorization decisions within 24 hours of making the decision.

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CATEGORY

Knox Keene Deficiency - Finding Number 1.4

DEFICIENCY

The Plan is operating at variance with its filed utilization management policy. UM policy states no auth required for MH services, but the provider directory states that auth is required.

CORRECTIVE ACTION SUMMARY

CCHP suspects that DMHC may have mistakenly reviewed a Medi-Cal document on Contra Costa County's website instead of the commercial document at issue.

Specifically, it appears that DMHC reviewed the Contra Costa Behavioral Health Services ("CCBHS") webpage and directory which is for CCHP Medi-Cal Members only, not CCHP's Commercial Members.

The statement reviewed by DMHC to call the CCHP Mental Health Authorization unit and does not state an authorization is required. Rather it states to call the CCHP unit for support in accessing outpatient mental health services.

For context, members in CCHP's Medi-Cal Managed Care plan who are attempting to access Non-Specialty Mental Health Services have the option of calling the ACCESS line (a call center staffed by CCHBS or can directly access a Provider by selecting from the Behavioral Health Provider list posted on their website located at https://cchealth.org/mentalhealth/provider/. To be clear, CCBHS did not require prior authorization for a Medi-Cal Member to access services at that time, nor does it currently.

In order to support CCHP Commercial members in the same way, CCHP has attempted to make clear that members are welcome to self-refer to Providers listed in the on-line directory. The CCHP Commercial Member directories are located at https://cchealth.org/healthplan/member-publications.php under County Employees (CCHP Commercial product line) or the on-line Provider directory on our website. For Commercial members who do not feel comfortable using online resources, the Plan routes calls for access and coordination to services to Plan staff who best know the network of providers and clinics.

REQUIRED ACTION
For clarity, CCHP will revise the statement at the bottom of the page at issue to ensure it is clear that an authorization is not required to access services to the following statement.

CORRECTIVE ACTION PLAN
CCHP will revise the statement at the bottom of the page at issue to ensure it is clear that an authorization is not required to access services to the following statement.

(Further, in the case of providers inadvertently submitting referrals to initiate mental health services despite no referral or authorization necessary, CCHP has created a "No Authorization Necessary" letter that can be provided to Member's and Providers. This communication ensures that members and provider are given timely reminder of ability to access mental health without input from the Plan.)

In order to prevent confusion, CCHP has also renamed the Behavioral Health Authorizations Unit (BHAU) to the Behavioral Health Department (BHD). This name better reflects the activity of the unit beyond authorization and including care coordination and quality assurance. This change went into effect December 2022.

Implementation: June 22, 2023

Management Position Responsible: Director of Provider Relations

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CATEGORY

Knox Keene Deficiency - Finding Number 1.5

DEFICIENCY

The Plan failed to establish and implement a quality assurance process that assesses and evaluates compliance with utilization management requirements. CCHP stated it does not generate UM reports for BH accessibility, availability, and COC.

CORRECTIVE ACTION SUMMARY

CCHP assessed and evaluated compliance with utilization management requirements during the audit period. Among other things, the following supportive documents are reviewed at CCHP's Quality Council where subsequent recommendations and actions result. These reports provide evidence that CCHP does generate UM reports for BH accessibility, availability, and COC. CCHP is more than happy to address that statement further should DMHC provide additional context.

REQUIRED ACTION
CCHP believes that it generates the required reports to satisfy the requirement at issue. Accordingly, CCHP submitted a factual inconsistency argument to DMHC on June 7, 2023. CCHP will continue to generate such reports to satisfy the requirements at issue.

CORRECTIVE ACTION PLAN
CCHP will continue to generate such reports to satisfy the requirements at issue.

Implementation: June 22, 2023

Management Position Responsible: Director of Quality Management, Director of Utilization Management

SUPPORTING INFORMATION

Supporting Materials	Explanation of Support
1.5 PNA Report 2020	Demonstrates an evaluation of utilization services.
1.5 PNA Report 2022	Demonstrates an evaluation of utilization services.
1.5 PNA Report 2021	Demonstrates an evaluation of utilization services.
1.5 HEDIS Report 2021	Demonstrates an evaluation of access, availability, and COC.
1.5 HEDIS Report 2020	Demonstrates an evaluation of access, availability, and COC.
1.5 HEDIS Report 2019	Demonstrates an evaluation of access, availability, and COC.
1.5 QC Minutes wBH 2022-09 FINAL	Demonstrates an evaluation of utilization services – including over/under and IRR.
1.5 QC Minutes wBH 2022-11 FINAL	Demonstrates an evaluation of utilization services – including over/under and IRR.
1.5 QC Minutes wBH 2023-02 SIGNED	Demonstrates an evaluation of utilization services – including over/under and IRR.
1.5 UM Committee Minutes_7-2022 to 05-2023	Demonstrates an evaluation of utilization services – including Denial Audits and IRR – both ensuring appropriateness of QC in UM processes related to mental and behavioral health review.

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CATEGORY

Knox Keene Deficiency - Finding Number 1.6

DEFICIENCY

Failure of customer service to identify all grievances.

CORRECTIVE ACTION SUMMARY

The CCHP Member Services Department has continued to monitor and train staff about grievance identification on an ongoing basis.

The Member Services Department conducts quarterly internal audits of member inquiries. The results from 2022 and Q1 2023 have resulted in zero findings. Please see the attached Internal Audit Summaries.

The proper identification of grievances also remains an item on the Member Services phone performance review form, which we use to monitor individual staff member calls. Please see MonitoringTemplate.xlsx.

The Member Services Manager has continuously reminded our staff members about filing a grievance any time a member expresses any kind of dissatisfaction. This has been captured in the included screenshot of a team chat. Please see: Chat Reminder of Grievance.docx.

In staff meetings, the Member Services Management Team had also reviewed grievances as a topic. The staff meeting on July 29, 2022, included reviewing cases improperly classified as inquiries from audit findings, and discussing these cases with the entire staff.

REQUIRED ACTION
CCHP will continue to monitor and train staff about grievance identification on an ongoing basis.

CORRECTIVE ACTION PLAN
CCHP will continue to generate such reports to satisfy the requirements at issue.

Implementation: June 22, 2023

Management Position Responsible: Director of Member Services

SUPPORTING INFORMATION

Supporting Materials	Explanation of Support
1.6 22 Q1 Audit 1.6 22 Q2 Audit 1.6 22 Q3 Audit 1.6 22 Q4 Audit 1.6 23 Q1 Audit	Internal audits of member inquiries
1.6 MonitoringTemplate	The proper identification of grievances also remains an item on the Member Services phone performance review form, which we use to monitor individual staff member calls.
1.6 Reminder	Ad hoc reminders to comply with the regulation at issue

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CATEGORY

Knox Keene Deficiency - Finding Number 1.7

DEFICIENCY

Failure to timely pay claims.

CORRECTIVE ACTION SUMMARY

CCLINK is the name of the Epic Tapestry Module for CCHP. It is CCHP's claim processing system. CCLINK has been updated to capture the "received by carrier date" to calculate the timeliness based on the claim received by our vendor who scan our paper claims (completed on August 31, 2022). CCHP is also engaged with a consulting company to work on improvement of claims turnaround time. The COO provided oversight to this implementation.

When CCHP reviewed and analyzed the claims turnaround processing time, we recognized two underlying issues that contributed to the delay in claims processing:

1. Additional information needed:

When CCHP needs additional information from providers in order to process the claims (e.g. W9 not received), we are unable to pause the claims when calculating the turnaround time. Even though the system has fields to enter information requested and received date, this process requires manual labor from staff and cannot be automated. We have brought this opportunity to IT and determined that this will require long-term effort.

2. Claims requiring manual intervention:

CCHP has many claims that are pending in our workqueues waiting for the claims examiners to manually review and process. We believe that by looking into the current pending rules, it can reduce the number of claims requiring manual intervention and hence, improve the turnaround time. We have hired a consulting company to review our current pending rules configuration and believe that this effort could produce a better outcome in a shorter time.

REQUIRED ACTION
CCHP must improve its ability to timely pay claims.

CORRECTIVE ACTION PLAN
CCHP is working on a key project to improve the claims and referral operations and system configuration. The changes of this project went live in June 8th, 2023. We anticipate the changes will reduce the claims turnaround time for 25% to 40% of the overall pending claims.

Implementation: June 8, 2023

Management Position Responsible: Chief Operations Officer

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CATEGORY

Knox Keene Deficiency - Finding Number 1.8

DEFICIENCY

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.

CORRECTIVE ACTION SUMMARY

CCHP conducted many trainings and educational opportunities for its staff regarding the above topics during the audit period. CCHP is uncertain whether DMHC requested this specific information during the audit, but CCHP has provided the attached information and is more than happy to make any additional information available.
First, CCHP introduced a mandatory four-hour employee training for new employees and was available to existing employees. The training was divided in two sections - Managed Care 101 and Cultural and Linguistics Program. Please see the attached attendance sheets and agendas.
Second, CCHP made a concerted effort to educate its providers and members. CCHP issued three (3) articles in the Member Newsletter discussing language access, interpreter services and health disparities as well as six (6) articles in the provider newsletter on using interpreter services and language access during the audit period. Please see the attached documents.

Third, CCHP provided extensive training during the audit period relevant to the Language Assistance Program requirements to plan staff on understanding the cultural diversity of the plan's enrollee population, being sensitive to cultural differences and how certain populations are more affected by health disparities. CCHP also shared detailed information on the importance of using interpreter and translation services and our step-by-step process for utilizing them. CCHP also used a video depicting a scenario where a patient did not receive interpreter services when needed, and the ramifications of that, followed by a group discussion.

During the training, staff was also given a detailed handout on how to use CCHP's interpreter/translation services and tips on how to work with interpreters. CCHP also addressed a separate topic on how to support members who are seniors or have disabilities. Please see the attached three (3) power point presentations that were used in the training offered during the audit period as well as instructions on how to use interpreter and translations services. CCHP also authored articles in Member and Provider Newsletter educating them about the use of interpreter services during audit period.

Fourth, the cultural diversity, race/ethnicity breakdown of the population was included on page 26 & 27 in the mandatory power point presentation called New Employee Orientation Managed Care 101 which was presented first (in the first hour of the training), the second power point covering language access, health disparities and policies on interpreter services was covered in a power point presentation called CCHP New Employee C&L Training. The training was four hours long, which was completed in a single day. Otilia Tiutin, Manager of Cultural and Linguistic Services conducted both sections of the training along with Managers from all CCHP Departments who came in to give an overview of each department functions. During the DMHC audit, both power point presentations were submitted and attendance sheets as part of the audit under section GD 17.

Fifth, the Managed Care 101 PPT included the cultural diversity of the plan population data breakdown, and the rest of the information was presented in the C&L Training PPT called New Emp C&L 3.21. Currently, CCHP has revised the Cultural & Linguistic Training, the cultural diversity of the plan members as well as cultural sensitivity are covered all in one power point presentation and includes detailed breakdown of race/ethnicity/ language, our threshold languages, and how to effectively use interpreter services as well as translation of documents. See power point presentation called New Emp C&L 3.23.

Finally, Contra Costa County Health Services Personnel Department also offer a class called "What's Culture Got To Do With It?" which covers in depth training on culture, beliefs, perception, biases, sexual orientation, ethnicity, physical and mental abilities and how they impart providing excellent services to our member population, health care disparities, and how they relate to quality of service. In 2019, we had 262 CCHS employees attending which included employees from the health plan, mental health, county hospital and clinics, public health, children services who all serve CCHP members. Please see the attendance list, Promotion document and What's Culture Participant Guide booklet.

REQUIRED ACTION
CCHP must ensure it continues to provide adequate 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. CCHP believes it is meeting this requirement. According, it has submitted a factual inconsistency argument to DMHC on June 7, 2023. CCHP is happy to address any additional concerns DMHC may have following its review.

CORRECTIVE ACTION PLAN
Please see the sections above.

Implementation: June 22, 2023

Management Position Responsible: Director of Quality Management

SUPPORTING INFORMATION

Supporting Materials	Explanation of Support
1.8 Staff IAT Steps	Attached you can find three power point presentations that were used in the training offered during the audit period as well as instructions on how to use interpreter/translations services.
1.8 NE Agenda 2.21, 1.8 NE Attend 2.21, 1.8 NE Agenda 8.20, 1.8 NE Agenda 3.19, 1.8 NE Attend 3.19, 1.8 Culture WB 2021, 1.8 NE Attend 8.20, 1.8 Culture 2019, 1.8 NE C&L 3.23, 1.8 NE C&L 3.21, 1.8 NE MC101 3.22,	During the DMHC BHI audit period, CCHP introduced a mandatory 4-hour Employee Training for new employees and was available to existing employees. The Managed Care 101 PPT included the cultural diversity of the plan population data breakdown, and the rest of the information was presented in the C&L Training PPT called New Emp C&L 3.21. Currently, CCHP has revised the Cultural & Linguistic Training, the cultural diversity of the plan members as well as cultural sensitivity are covered all in one power point presentation and includes detailed breakdown of race/ethnicity/ language, our threshold languages, and how to effectively use interpreter services as well as translation of documents.
1.8 SPD Awareness	Evidence of training related to Seniors and Persons with Disabilities.
1.8 Culture WB 2021 1.8 Culture 2019, 1.8 Culture Promo	This document supports Contra Costa County Health Services Personnel Department's class called “What’s Culture Got To Do With It.”