DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

CHINESE COMMUNITY HEALTH PLAN
DBA BALANCE BY CCHP

DATE: APRIL 11, 2025

Behavioral Health Investigation
Balance by CCPH
April 11, 2025

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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 is conducting focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California law 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 Balance by CCHP (Plan) was included in Phase Three.

On August 14, 2023, the Department notified the Plan of its BHI covering the time period of April 1, 2021 through March 31, 2023. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan and its Pharmacy Benefit Manager, MedImpact, February 13, 2024 through February 15, 2024 and September 25, 2024.

The BHI uncovered **eleven** Knox-Keene Act violations in the areas of Appointment Availability and Timely Access, Utilization Management, including Triage and Screening, Quality Assurance, and Grievances and Appeals:

1. The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards.
2. The Plan does not have a process to ensure enrollees who call the Plan or submit grievances about behavioral health (BH) appointment requests are offered appointments that meet timely access standards.
3. The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services.
4. The Plan does not monitor network adequacy, including timely and geographic accessibility, for Pervasive Developmental Disorder and autism services.
5. The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.
6. The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.
7. Customer Service Representatives are not consistently knowledgeable and competent regarding enrollee questions and concerns.

[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 does not have a process for monitoring and evaluating the effectiveness of behavioral health triage and screening services for both non-urgent and urgent services.
9. The Plan is operating at variance with its filed provider directory policies and procedures.
10. The Plan is operating at variance with its filed *Provider Appointment Access Standards* policy.
11. The Plan does not consistently identify oral expressions of dissatisfaction as grievances.

Additionally, the Department identified the following **five** barriers to care not based on Knox-Keene Act requirements in the areas of Appointment Availability and Timely Access, Quality Assurance, and Cultural Competency, Health Equity and Language Assistance, and Pharmacy:

1. The Plan does not provide enrollees with sufficient messaging about how to access behavioral health services and enrollees experience difficulties when trying to obtain behavioral health services.
2. The Plan's requirement for enrollees to obtain a PCP referral for behavioral health services may delay or present a barrier to timely access to services.
3. The Plan does not have a system to track customer service calls for repeat callers to identify trends, patterns or problems.
4. The Plan lacks processes for ensuring delivery of culturally competent behavioral health care as well as monitoring and addressing disparities among the enrollee population.
5. Neither the Plan nor its Pharmacy Benefit Manager has a process to assist enrollees with reminders for medication compliance.

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 initiatives/operations resulting in positive impact 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 deficiencies. In the Phase Three Summary Report, the Department will provide recommendations for the barriers to care not related to 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 coverage for the medically necessary treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

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

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine medical 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, 2021 through March 31, 2023, the Department requested and reviewed Plan documents, files, and data, and conducted interviews with Plan and MedImpact 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

[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.

- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance

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 Department's Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. Despite the Department's attempt to engage Plan enrollees and providers in interviews for this BHI, the Department received no response from either Plan enrollees or providers willing to be interviewed.

PLAN BACKGROUND

Chinese Community Health Plan, dba Balance by CCHP, obtained its Knox-Keene license in 1987 and is headquartered in San Francisco. The Plan is a full-service health care service plan licensed to provide health care services to commercial and Medicare enrollees. The managed care plans include health maintenance organizations and point-of-service plans. As of March 31, 2023 (the final quarter of the BHI review period), the Plan had 6,120[6] enrollees in its commercial lines of business. The Plan operates in San Francisco and San Mateo counties.

SECTION I: KNOX-KEENE ACT VIOLATIONS

APPOINTMENT AVAILABILITY AND TIMELY ACCESS

#1: **The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards.**

Statutory/Regulatory Reference(s): Sections 1367.03(a)(1), 1367.03(a)(5)

Supporting Documentation:
- Plan policy 42-040 *Provider Appointment Access Standards* (revised March 2023)
- *Provider Appointment Availability Survey* results (2021, 2022)

Assessment: Health plans must provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[7] Plans must also ensure their networks have adequate capacity and availability of licensed health care providers to offer enrollees

[6] Source: DMHC Dashboard 2023, Q1.
[7] Section 1367.03(a)(1).

appointments within timely access standards.[8] Timely access standards are in place for both urgent and nonurgent appointments, with limited exception.[9] Nonurgent appointments with nonphysician behavioral health providers must be provided within 10 business days of the request, and nonurgent appointments with specialty care physicians within 15 business days of the request.[10] Urgent appointments that do not require prior authorization must be offered within 48 hours of the request for an appointment. Urgent appointments that require prior authorization must be offered within 96 hours of the request for an appointment. [11] Follow-up appointments with a non-physician mental health or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment.[12]

The Plan's *Provider Appointment Access Standards* policy includes the statutory timeliness requirements and appointment access standards.[13] This policy also includes a process for monitoring compliance with required timely access standards, which states the Plan will "collect and annually analyze data to measure performance against standards for primary care, specialist care and behavioral healthcare access." The policy contends "[c]ompliance monitoring is designed to accurately measure the accessibility and availability of contracted providers" through tracking and documenting network capacity, conducting annual member experience surveys, administering annual Provider Appointment Availability Surveys (PAAS), and monitoring grievances and appeals, among other things.[14]

As explained below, the Plan's PAAS data, interviews with the Plan and other data and information demonstrate the Plan was unable to adequately monitor its compliance with timeliness requirements or ensure enrollees were provided with behavioral health services consistent with timely access standards.

Interviews

During interviews, Plan representatives, including the Director of Population Health Management, stated the Plan relies primarily on PAAS data for tracking and evaluating appointment wait times. PAAS data was also submitted to the Department by the Plan in response to a request for documents and tools used for tracking and evaluating wait time

[8] Section 1367.03(a)(5).
[9] The exception to timely appointment requirements includes cases in which the referring or treating provider, or the triaging provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. In such cases, the waiting time for an appointment may be extended (Section 1367.03(a)(5)(H)).
[10] Section 1367.03(a)(5)(E) and (a)(5)(D), respectively. Wait times may be extended if the referring or treating provider determined and noted in the enrollee's record that a longer wait time will not have a detrimental impact on the health of the enrollee. (Section 1357.03(a)(5)(H))
[11] Section 1367.03(a)(5)(A), (B).
[12] Section 1367.03(a)(5)(F)
[13] *Provider Appointment Access Standards* policy, pages 1- 8. Although Section 1367.03(a)(5)(B) requires urgent care appointments for services requiring prior authorization be offered within 96 hours of the appointment request, the Plan's policy requires all urgent care appointments to be offered within 48 hours of the request.
[14] *Provider Appointment Access Standards* policy, pages 11-12.

compliance.[15] However, as explained below, the limited PAAS data obtained by the Plan was not reliable for determining whether appointments with psychiatrists and non-physician behavioral health providers were timely. The Plan conceded it was challenging to get providers to participate in the surveys.

The Plan also stated that during the BHI review period between 2023 and 2024, the Plan was not tracking, analyzing or reporting on provider-to-enrollee ratios because the position of Manager of Plan Network Management was vacant. Tracking enrollee-to-provider ratios is another method plans use when evaluating accessibility. Finally, the Director of Customer Service stated if a member expresses difficulty getting an appointment, the Plan will file a grievance, but stated the Plan does not monitor timelines for appointment rescheduling. This means the Plan relies on enrollee reports of difficulties rather than taking an affirmative data review approach to understanding accessibility problems. Moreover, as discussed in Knox-Keene Act Violation #9 below, the Plan does not consistently identify grievances received during calls with enrollees, further limiting the available data which could be used to evaluate access.

Measurement Year (MY) 2021 and 2022 PAAS Data

The Plan provided its PAAS results for MY 2021 and 2022. Provider response data is summarized in the tables below for psychiatrists and non-physician mental health providers.

TABLE 1a: MY 2021 PAAS Results: HMO Provider Response[16]

MY 2021	Number of providers who were sent PAAS survey	Target sample size	Number of responding providers	Overall Response rate	% of Target achieved
Psychiatrists	249	162	14	6%	9%
Non-Physician Mental Health Providers	205	146	47	23%	32%

[15] Crosswalk request BHIQA7.

[16] The data presented in Table 1a pertains to the Plan's HMO network. Data for the Plan's PPO network was substantially similar since most providers who were part of the Plan's HMO network were likely also part of the Plan's PPO network. The number of PPO Psychiatrists who were sent the PAAS survey was 244, and the overall response rate was 6%. The number of PPO Non-Physician Mental Health Providers who were sent the PAAS survey was 198 and the overall response rate was 21%.

TABLE 1b: MY 2022 PAAS Results: HMO and PPO Provider Response[17]

MY 2022	Number of providers who were sent PAAS survey	Target sample size	Number of responding providers	Overall Response rate	% of Target achieved
Psychiatrists	159	118	2	1%	2%
Non-Physician Mental Health Providers	227	151	12	5%	8%

As shown in the tables above, for both MY 2021 and 2022, the number of psychiatrists and non-physician mental health providers that responded to the PAAS fell markedly below the target number of respondents. Because the response rates were so low, the PAAS results were insufficient to accurately measure timely access to behavioral health services. Such low response rates cannot be used as a reliable measure of appointment accessibility across all psychiatrists and non-physician mental health providers. Because the Plan relies on PAAS results, and the PAAS results are not an accurate measure of timely access, the Plan was not able to sufficiently evaluate whether its provider network had adequate capacity and availability to offer enrollees appointments within timely access standards, as required by Section 1367.03(a)(5).

Conclusion: Health plans must have processes in place to accurately evaluate and ensure their networks have adequate provider capacity and availability to offer enrollees behavioral health services within specified timely access standards, with limited exceptions[18]. The information provided by the Plan during interviews demonstrated the Plan was not consistently or reliably monitoring appointment accessibility during the BHI review period. Review of the Plan's PAAS data and information gathered during interviews showed the Plan's use of PAAS data to monitor compliance with timely access standards was insufficient to ensure enrollees are able to get behavioral health appointments within statutory timeframes and as set forth in the Plan's policies and procedures. As a result, the Department finds the Plan in violation of Sections 1367.03(a)(1) and 1367.03(a)(5).

#2: The Plan does not have a process to ensure enrollees who call the Plan or submit grievances about BH appointment requests are offered appointments that meet timely access standards.

Statutory/Regulatory Reference(s): Sections 1367.03(a)(5), 1368(a)(1); Rules 1300.68(a)(4), 1300.67.2.2(b)

[17] The data presented in Table 1b pertains both to the Plan's HMO and PPO networks as the data was identical for both networks.
[18] See footnote 9 for the exception to the requirement to meet timeliness standards.

Supporting Documentation:

- Policy 42-040 *Provider Appointment Access Standards* (Revised April 2023)
- Policy 42-004 *Access Standards for Health Care Services* (Reviewed August 2003)
- *Member Services Workflow for Customer Inquiries* (undated)
- Log C, enrollee Inquiry Log

Assessment: Plan grievance systems must have reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.[19] 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. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance."[20] A grievance is considered resolved when the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.[21]

A grievance regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.[22] When an enrollee requests a behavioral health appointment, plans are required to offer appointments within specified timely access standards, the timeframe for appointments depending on the urgency of the needed service and the type of service.[23] For example, health plans must offer an appointment within 48 hours of a request for an urgent appointment for a service not requiring prior authorization and within 96 hours of the request for an urgent appointment when prior authorization is required.[24] Requests for non-urgent appointments with a specialist physician require offering an appointment within 15 business days of the request, and requests for non-urgent appointments with non-physician mental health care providers require the plan to offer an appointment within 10 business days of the request.[25] Follow-up appointments with a non-physician mental health or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment.[26]

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[19] Section 1368(a)(1)
[20] Rule 1300.68(a)(1)
[21] Rule1300.68(a)(4)
[22] Rule 1300.67.2.2(b)
[23] Section 1367.03(a)(5); Rule 1300.67.2.2(c)(5) As mentioned in footnote 9, the exception to these timely appointment requirements includes cases in which the referring or treating provider, or the triaging provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. In such cases, the waiting time for an appointment may be extended (Section 1367.03(a)(5)(H)).
[24] Section 1367.03(a)(5)(A), (B); Rule 1300.67.2.2(c)(5)(A), (B)
[25] Sections 1367.03(a)(5)(D), (E); Rules 1300.67.2.2(c)(5)(D), (E)
[26] Section 1367.03(a)(5)(F)

Therefore, when an enrollee notifies a health plan they are having difficulty obtaining a behavioral health appointment or are experiencing delays in scheduling an appointment, the plan must consider the expression of dissatisfaction as a grievance and an initial request for an appointment.[27] When a request for an appointment is made, the plan is required to offer an appointment within the applicable timely access standards.[28] Failure to do so means the plan has not adequately considered and rectified or resolved the grievance.[29] Adequate consideration and resolution require offering the enrollee an appointment within timeliness standards because obtaining an appointment was the substance of the grievance.

Review of the Plan's documents, including policies and procedures, grievance processes, workflows and log data, failed to demonstrate the Plan has a process to identify expressions of dissatisfaction regarding a delay or difficulty in obtaining a behavioral health appointment as a request for an appointment or ensure the enrollee is offered an appointment within timely access standards. The Plan's *Provider Appointment Access Standards* policy included the timeliness standards for the various urgent and non-urgent appointment types, but did not describe a process for identifying grievances about delays or difficulties finding an appointment as requests for appointments.

The Plan's *Provider Appointment Access Standards* policy recited the statutory requirement stating a grievance regarding delay or difficulty obtaining an appointment may constitute an initial request for an appointment in addition to timeliness standards. The policy stated network capacity was tracked and documented and suggested grievances and appeals are monitored. However, the policy did not describe how or what grievances and appeals are monitored for or a process for identifying as requests for appointments those grievances involving delays or difficulties finding an appointment.

The Plan's *Member Services Workflow for Customer Inquiries* document was a flowchart showing how calls from enrollees are handled. The document shows that when an enrollee expresses dissatisfaction, the customer service representative follows one of two paths:

1. The customer service representative assists in filing an appeal or grievance, routing the grievance or appeal to the Grievance Department for processing, review and resolution, or
2. For exempt grievances, "provides a solution within [the] next business day" and files and documents the issue as an exempt grievance.[30]

Neither the *Member Services Workflow for Customer Inquiries* document, nor any grievance document, describes a process for referring the call to someone responsible for ensuring a timely appointment is offered to the enrollee.

[27] Rules 1300.68(a)(1), 1300.67.2.2(b)
[28] Section 1367.03(a)(5)
[29] Rule1300.68(a)(4)
[30] An exempt grievance is a grievance not involving a coverage dispute, a disputed service involving medical necessity, or experimental or investigational treatment, and resolved by the next business day following receipt. (Section 1368(a)(4)(B)).

Review of the Inquiry Call Log showed that when an enrollee complained about the inability to get a timely appointment, the Plan provided the enrollee with a list of providers and instructed the enrollee to consult with their primary care provider to obtain a referral. The Plan did not take steps to ensure a timely appointment was offered to the enrollee.

Example:[31] The enrollee called the Plan stating he was having difficulty finding an in-network psychiatrist. He stated the providers to whom he was referred by his primary care physician were either not accepting new patients, or the wait time to get an appointment exceeded two months. In response, the Plan customer service representative emailed the enrollee a list of mental health providers and instructed the enrollee to "discuss with your PCP for referral." The grievance was marked "resolved" the same date and time as the call was received.

In this case, the enrollee's call concerned difficulty obtaining a timely, non-urgent appointment with a specialist physician. The Plan should have identified the expression of dissatisfaction as a grievance and a request for an appointment.[32] Timely access standards for a non-urgent appointment with a psychiatrist, a specialty physician, required the Plan to offer an appointment within 15 business days of the request.[33] The Plan's response of emailing a list of providers to the enrollee and instructing him to contact his PCP for a referral failed to comply with the Plan's obligation to identify and resolve the grievance and to identify the grievance as a request for an appointment, in violation of Section 1368(a)(1), Rule1300.68(a)(4), Rule 1300.67.2.2(b)

Conclusion: Review of Plan documents and case files demonstrates the Plan lacks a process to identify expressions of dissatisfaction regarding a delay or difficulty in obtaining a behavioral health appointment as a request for an appointment, and fails to ensure the enrollee is offered an appointment within timely access standards. The Plan thereby fails to adequately consider and rectify the enrollee's grievance. Accordingly, the Department finds the Plan in violation of Section 1367.03(a)(5) and Rules 1300.68(a)(1), 1300.68(a)(4) and 1300.67.2.2(b).

#3: **The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services.**

Statutory/Regulatory Reference(s): Sections 1367.27(j)(3), 1367.27(o)(1) and 1367.27(o)(2)(B)

Supporting Documentation:

- *Provider Directory* policy (reviewed February 2024)
- *Specialist Referrals* policy (revised June 2022)
- 81 Plan Inquiry Files (April 1, 2021, through March 31, 2023)

Assessment: Sections 1367.27(j)(3) and 1367.27(o)(1) require plans to promptly investigate a reported inaccuracy of information in the provider directory or directories,

[31] Entry from Inquiry Log, File ID #FLO388072.
[32] Rules 1300.68(a)(1); 1300.67.2.2(b).
[33] Rule 1300.67.2.2(c)(5)(D)

and, if necessary, undertake corrective action within 30 business days of receipt of the report by either verifying the accuracy of the information or updating the information to ensure the accuracy of the directory or directories. Moreover, Section 1367.27(o)(2)(B) specifies the Plan must document the receipt and outcome of each reported inaccuracy, including any updates or changes made to its directory or directories.

Similarly, the Plan's *Provider Directory* policy requires the Plan to "document the receipt, investigation, and outcome of each reported potential directory inaccuracy. . . ."[34] The policy also requires the Plan to take "no more than 30 business days to verify the accuracy of directory information reported to be inaccurate and to update or correct its directory "at the next required [directory] update. . . ."[35]

The Plan's process for obtaining behavioral health services is to have enrollees reach out to their primary care providers (PCP) for a referral. The PCP submits a referral to the Plan identifying an in-network provider. The Plan's *Specialist Referrals* policy states "Members may require medically necessary services that go beyond the scope of their PCP. When this occurs, the PCP refers the member to an appropriate CCHP participating specialist." The policy also states: "When a CCHP PCP identifies the need for a referral, the PCP may refer members to CCHP specialist physicians, including behavioral health specialists as medically necessary."

Interviews

The Plan provided no documents to demonstrate it investigates potential provider directory inaccuracies related to enrollee calls handled by customer service representatives. During interviews, the Department asked how the call center addresses provider directory issues reported by enrollees. The Director of Customer Service stated customer service representatives (CSRs) will leave a message with the provider to attempt to verify the information and will internally follow-up by asking the Plan's provider contracting department whether it has any updated information about the provider. Also, if an enrollee reports to a CSR that a provider was no longer accepting new patients or the enrollee's health care coverage, the CSR is trained to escalate the report to a grievance. The Director of Customer Service stated it is the responsibility of the call center to report the potential inaccuracy to the provider contracting department, and that the referral would be in the CSRs call notes.

File Review

The Department reviewed a total of 81 enrollee call inquiry files[36] involving behavioral health issues, including audio recordings of the calls. Of the 81 files reviewed, six files involved enrollee statements indicating potential provider directory inaccuracies.[37] None of the six files in which a potential directory inaccuracy was reported included documentation noting the potential inaccuracy or indicating the potential inaccuracy was

[34] *Provider Directory* policy, page 3.
[35] *Provider Directory* policy, page 3.
[36] Duplicate files were excluded from the original 94 Inquiry files.
[37] Plan Inquiry Files: LFC_PI Files 8, 16, 20, 53; DMHC LFC_MH Files 9, 10.

referred, investigated or reported for further determination and potential correction as warranted. Additionally, there was no documentation indicating the files were escalated as grievances, as described during interviews.

Case Examples

- **Inquiry File LFC_MH #9:** The enrollee called the Plan concerning his search for a psychologist. He stated he called a provider listed in the Plan's provider directory, but was told by the provider's office that the provider does not take private insurance. The CSR checked the provider's name in the directory and told the enrollee that provider was not part of the network. The CSR agreed to send a provider list to the enrollee. The file contained no documentation indicating the potential provider directory inaccuracy was investigated.

- **Inquiry File LFC_MH #10:** The enrollee called the Plan and stated her family doctor referred her to a psychiatrist, but when the enrollee called, the psychiatrist's office told her they were not taking new patients. The CSR attempted to conference call the psychiatrist's office, but there was no answer. The CSR attempted to contact another provider, but received a voice mail recording. The CSR told the enrollee to call the CSR back after lunch time for further help in contacting the providers. There was no documentation in the file indicating the potential provider inaccuracy was investigated to determine whether the provider was accepting new patients.

- **Inquiry File LFC PI #8:** The enrollee called the Plan asking for help finding a substance use disorder (SUD) provider. The enrollee stated his family doctor referred him to a facility for services, but the enrollee called and discovered the facility no longer provided SUD services. The CSR told the enrollee SUD services are provided through Hill Physicians Medical Group (HPMG). The enrollee said he called HPMG, but their provider list was not updated, stating some of the phone numbers on the list did not work. There was no documentation in the file indicating the potential provider directory inaccuracies reported by the enrollee were investigated.

- **Inquiry File LFC PI #20:** The enrollee called the Plan stating they needed to find a mental health therapist. They obtained a list six months prior, but wanted an updated list in case any provider information had changed. The CSR told the enrollee "It's the same list" and that as far as she knew, the list had not changed. The enrollee stated she called a provider on that list and was told the provider is no longer contracted with the Plan. The CSR stated she would send an updated list, but there was no documentation in the file indicating the potential provider directory inaccuracy reported by the enrollee was investigated.

Conclusion: Sections 1367.27(j)(3) and 1367.27(o)(1) require health care service plans to promptly investigate a reported inaccuracy of information in the provider directory or directories, and, if necessary, undertake corrective action within 30 business days of receipt of the report. Section 1367.27(o)(2)(B) requires the receipt and outcome of each

reported inaccuracy to be documented. The Plan's policies require that customer service agents file a grievance upon receipt of a report of a provider directory inaccuracy and document it in the notes so it can be investigated. Review of the Plan's call inquiry files showed when enrollees report potential provider directory inaccuracies, the issues are not documented, reported, investigated or escalated. Therefore, the Department finds the Plan in violation of these statutory requirements.

#4: **The Plan does not monitor network adequacy, including timely and geographic accessibility, for Pervasive Developmental Disorder and autism services.**

Statutory/Regulatory Reference(s): Section 1374.73(b); Rule 1300.74.73(a)(3)(D)

Supporting Documentation:
- Document Crosswalk (submitted September 26, 2023)
- Post Interview Document Requests sent to the Plan on September 27, 2024

Assessment: Section 1374.73(b) requires full-service health plans to provide coverage for behavioral health treatment of pervasive developmental disorder (PDD) or autism and to maintain an adequate network that includes qualified autism providers. Rule 1300.74.73(a)(3)(D) requires plans, upon request, to submit information to determine network adequacy to ensure enrollees are receiving PDD and autism services, including timely screening, diagnosis, evaluation and treatment.

The Department requested the Plan provide copies of documents describing how the Plan determines provider network adequacy for PPD and autism services, including how geographic accessibility and timely access are being met.[38] The request also asked for a report on the Plan's current network adequacy for these services. The Plan's initial response, submitted on the Crosswalk on September 26, 2023, was the generic reply "UM Policies and Guidelines."

On September 27, 2024, the Department sent the Plan several additional document requests. One request asked the Plan to submit:

> Copies of reports related to tracking the availability of providers able to treat Pervasive Developmental Disorder (PDD) and autism services, including geographic accessibility reports.[39]

On October 4, 2024, the Plan submitted a response, stating it does "not currently have any reports tracking the availability of providers to treat these specific disorders." The Plan instead submitted a spreadsheet listing individual provider and facility names, addresses, licensure type, facility type and other information, stating that "in the list provided, there are providers that treat autism and other behavioral disorders." Nothing in the spreadsheet demonstrated tracking or monitoring of timely or geographic accessibility of PDD and autism providers.

[38] Crosswalk sent to the Plan on August 14, 2023, request BHIAA_NP7.
[39] Request #19 on the CCHP Post Interview Document Requests, submitted to the Plan on September 27, 2024.

Conclusion: Section 1374.73(b) requires the Plan to maintain an adequate network of providers able to treat PDD and autism. Rule 1300.74.73(a)(3)(D) requires plans, upon request, to submit information to determine network adequacy to ensure enrollees are receiving PDD and autism services, including timely screening, diagnosis, evaluation and treatment.

Based on the Plan's response, the Department determined the Plan does not track, and is therefore unaware of which providers in its network are able to provide timely and geographic accessibility to PDD and autism services. Therefore, the Department finds the Plan in violation of Section 1374.73(b) and Rule 1300.74.73(a)(3)(D).

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#5: **The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.**

Statutory/Regulatory Reference: Section 1374.197(a)

Supporting Documentation:

- Plan *Credentialing Program* (January 1, 2024)
- Plan Credentialing Report (undated)

Assessment: Beginning January 1, 2023, health plans that cover behavioral health services and credential behavioral health providers "shall assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the…plan shall notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete."[40]

The Plan's *Credentialing Program* policy describes how the Plan reviews new and renewing applicants to the Plan's network of providers. On page six, the policy states "[f]ollowing the Credentialing Committee's decision, the applicant shall be notified with written notification within 7 business days to verify receipt and to inform them that their application has been completed."

To determine compliance with Section 1374.197(a), the Department reviewed the Plan's Credentialing Report and interviewed Plan staff about its credentialing process.

During interviews, the Plan explained that after receiving a credentialing application from an individual provider or provider group, the Plan notifies the individual or provider group that it received the application and that the credentialing process has commenced. This notice does not inform the applicant of whether the application is complete. The Plan sends batches of applicant information to its credentialing vendor, Council for Affordable Quality Healthcare (CAQH). CAQH reviews the application submissions, determines whether the applications are complete and notifies the Plan of any missing provider

[40] Section 1374.197(a). The requirements in this section apply to plan-provider contracts issued, amended or renewed on or after January 1, 2023.

information, a process which the Plan stated takes approximately two weeks. The Plan then notifies providers or provider groups of any missing information to be submitted. At that time, however, providers and provider groups are not notified whether their application is complete, only of missing information. Further, even if the notification of missing information constituted notice that the application was not complete, it would not be timely since the notice was not made within seven business days of receipt of the application, as required.

Once all information has been received, applications are sent to the Plan's Credentialing Committee, which meets quarterly. The Credentialing Committee reviews the applications and makes decisions about whether to approve each application. Providers and provider groups are notified that their applications are complete only after the Credentialing Committee completes its review. Applications for providers and provider groups that have been approved are sent to the Plan's Chief Medical Officer (CMO) for finalization.

When asked about the seven business day requirement to notify providers about the completeness of their credentialing application, the Plan explained it is not possible for the Plan to notify the applicant within seven business days of receipt of an application because once the Plan sends applicant information to CAQH, CAQH takes approximately two weeks to validate applicant information.

Conclusion: Section 1374.197(a) requires plans, within seven business days of receipt by its credentialing department of a credentialing application, to notify the applicant of receipt and inform the applicant whether the application is complete. The Plan's *Credentialing Program* policy and credentialing review process incorrectly bases the notice timeframe requirement on the Credentialing Committee's decision rather than the date the Plan's credentialing department received the application. Furthermore, the explanation of the Plan's process and information provided in the Credentialing Report confirm the Plan is not notifying applicants within seven business days of receipt of an application. Therefore, the Department finds the Plan in violation of this statutory requirement.

QUALITY ASSURANCE

#6: The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.

Statutory/Regulatory Reference(s): Section 1367.265(a).

Supporting Documentation:

- Plan policy *41-UM-ADMIN 904 Maternal & Infant Health Equity Program* (effective January 1, 2025)
- Plan policy *Health Care Coverage- Maternal and Pandemic-Related Mental Health Conditions* (effective July 1, 2023)
- Edinburgh Postnatal Depression Scale tool
- Plan document 41-UM-ADMIN 1207 Attachment B: Depression Screening Tools

Assessment: By July 1, 2023, plans were required, pursuant to Section 1367.625(a), to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Maternal mental health programs must "include quality measures to encourage screening, diagnosis, treatment and referral." The term "maternal mental health" is defined as "a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression."[41] The Department found the maternal mental health program documents submitted by the Plan do not demonstrate compliance with the requirements of Section 1367.625.

The Department asked the Plan to provide a description of its maternal mental health program.[42] The Plan provided a copy of its *Maternal & Infant Health Equity Program*, a two-page policy describing the Plan's intent to implement use of doulas beginning January 2025. This policy was not yet in effect during the Plan's BHI review period.

The Department also requested copies of quality measures, as well as documents demonstrating efforts to encourage and improve maternal mental health screening, diagnosis, treatment and referral.[43] Finally, the Department requested reports pertaining to the review, monitoring and tracking of the maternal mental health program.[44] The Plan provided the following additional documents:

- The Plan's *Health Care Coverage- Maternal and Pandemic-Related Mental Health Conditions* policy
- A copy of the Edinburgh Postnatal Depression Scale tool
- A table listing two Plan enrollees, their diagnoses, claim numbers and one date of service for each enrollee
- A table listing the name of 10 Depression Screen Tools,[45] the method each tool uses for scoring and the number of questions comprising each tool

The Plan's *Health Care Coverage-Maternal and Pandemic-Related Mental Health Conditions* policy includes a section titled: "Maternal Mental Health Program Guideline Requirements for Mental Health Screening Tools." Item 1 under this section states practitioners must use an evidence-based screening tool when providing a mental health screening, and identifies the Plan's preferred screening tool for maternal mental health screening as the Edinburgh Perinatal Depression Scale Questionnaire which is "self-administered by the member." According to the policy, providers are "expected to provide the questionnaire to the member to fill out and return to the practitioner" with the screening required to occur "at least once during each pregnancy and once within 12 weeks following birth of the child." The policy also includes a recommended schedule of more frequent screening. If results indicate potential depression or other mental health

[41] Section 1367.625(b)(2).
[42] Crosswalk request BHIPRP1.
[43] Crosswalk request BHIPRP6(b)(1), (2).
[44] Crosswalk request BHIPRP6(b)(3), (4), and DMHC Post Interview Document Requests, submitted September 27, 2024, Question #24.
[45] The 10 depression tools listed included: (1) Prime MD PHQ-2, (2) PHQ-9, (3) Beck Depression Inventory, (4) Beck Depression Inventory II, (5) Center for Epidemiologic Studies Depression Scale, (6) Depression Scale, (7) Duke Anxiety-Depression Scale, (8) Hopkins Symptom Checklist, (9) Zung Self-Rating Depression Scale, and (10) Cornell Scale for Depression in Dementia.

condition, the enrollee "may be referred for mental health services." The policy states "Members may refer directly to CCHP in-network mental health service providers that can be found on our website (https://cchphealthplan.com/provider-search/)."

The Edinburgh screening tool recommended by the Plan policy, a copy of which the Plan submitted, is described as a tool "to assist health professionals in detecting mothers suffering from [postpartum depression]."[46] However, the maternal mental health program described by Section 1367.625, including the definition of maternal mental health, contemplates the screening, diagnosis and treating of conditions *not limited to* postpartum depression. Although the Plan submitted a document listing the names of 10 depression screening tools, there was no evidence the 10 screening tools, or tools other than the Edinburgh tool, are provided by the Plan to contracted Plan providers, or that the Plan provides other tools to screen, diagnose, treat or refer enrollees with maternal mental health conditions. Also, there was no indication of monitoring or follow-up to determine how many enrollees were given the Edinburgh screening tool, the number that completed and returned it to their provider, or other data regarding use of a maternal mental health program. The listing of two enrollees who each received one date of service related to a maternal mental health diagnosis is not sufficient to demonstrate the Plan is promoting quality and cost-effective outcomes.

In response to the request for quality measures and efforts to improve use and referral to maternal mental health services, the Plan responded:

> Other than the HEDIS measure Prenatal and Postpartum Care, CCHP did not, at the time of the review period, have any targeted efforts to improve screening, treatment, and referral to maternal mental health services.

The Plan's response indicates it has no process to monitor the quality of its maternal mental health program or its compliance with program requirements.

Conclusion: Based on the documents provided, the Plan has not demonstrated its maternal mental health program is designed to promote quality and cost-effective outcomes, nor does it include quality measures to encourage screening, diagnosis, treatment and referrals, as required by Section 1367.625.

#7: **Customer Service Representatives are not consistently knowledgeable and competent regarding enrollee questions and concerns.**

Statutory/Regulatory Reference: Section 1367.03(a)(10)

Supporting Documentation:

- *Cultural Competency* policy 42-009 (revised June 2022)
- *Member Satisfaction* policy (Revised March 2023)
- 2022 Commercial Adult Report of Plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (June 21, 2022)

[46] Edinburgh Postnatal Depression Scale (EPDS) Scoring and Other Information.

- 2022 Qualified Health Plan Enrollee Experience Survey (July 27, 2022)
- CCHP UCCX Member Services Call Flow v 3.5 (December 17, 2020)
- Interactive Voice Response script (undated)
- *Member Services Workflow for Customer Inquiries* (undated)
- *Operational Chart in Relation to Utilization Management Authorization Process* (undated)
- 81 Plan Inquiry Files (April 1, 2021, through March 31, 2023)

Assessment: Health plans must ensure "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 10 minutes."[47] This statutory requirement has two components, a timeframe component and a knowledge and competency component. First, the wait time component limits the wait time to speak with a customer service representative to 10 minutes. Second, the customer service representative who speaks with the enrollee must be knowledgeable and competent about the enrollee's questions and concerns. Both components must be met for a Plan to comply with the statute.

Rather than ensuring customer service representatives are knowledgeable and competent about enrollee questions and concerns, the Plan's customer service representatives respond to inquiries about behavioral health services by offering to email provider lists to enrollees and instruct enrollees to contact their primary care provider for a referral for behavioral health services.

Plan Documents:

The Department requested policies and procedures, training materials, job aids, scripts and other documents pertaining to use by, or training of, customer service staff.[48] Requested documents included those measuring the quality of customer service, identifying and correcting problems enrollees face in navigating the customer service process, training materials, how customer service handle expressions of dissatisfaction and responding to requests for assistance finding behavioral health providers, among other things. In response, the Plan provided several documents.[49] None of the submitted documents included training materials, attendance sheets or competency testing. The *Member Services Workflow for Customer Inquiries* showed that when an enrollee expresses dissatisfaction, the customer service representative should help the enrollee file a grievance or, if able to resolve it by the next business day, document it as an exempt grievance. The *Operational Chart in Relation to Utilization Management Authorization Process* instructed customer service representatives on how to respond to inquiries about authorization status or requests for services. The CSR is instructed to

[47] Section 1367.03(a)(10)
[48] Crosswalk requests BHICS1, BHICS4, BHICS5, BHICS7, BHICS8, BHICS9, BHICS10
[49] The *Cultural Competency* policy 42-009, *Member Satisfaction* policy, 2022 Commercial Adult Report of Plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, 2022 Qualified Health Plan Enrollee Experience Survey, CCHP UCCX Member Services Call Flow v 3.5, Interactive Voice Response script, *Member Services Workflow for Customer Inquiries*, and *Operational Chart Relation to Utilization Management.*

check eligibility and authorization, provide the authorization status, reach out to the Utilization Department for information, or make a conference call to the provider and assist in submitting a prior authorization request to the Utilization Department when needed. None of the documents provided instruction or guidance on identifying available and appropriate providers, making appointments or providing other types of substantive assistance to enrollees.

Surveys:

The Plan's *Member Satisfaction* policy describes means by which the Plan's Quality Improvement Department collects and analyzes data to monitor and evaluate enrollee satisfaction and identify areas for improvement. One of the methods used to collect this data is the enrollee survey. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a standardized survey sent to enrollees asking them about their experiences with health plans and health care services. The Plan's 2022 Commercial CAHPS Survey results were based on a 14.4% response rate.[50] This report showed that of the approximate 14% of respondents, only 44% answered "always" to the question of whether customer service provided information or help, 31% responded "never or sometimes" and 24% responded customer service "usually."

The Plan's 2022 Qualified Health Plan Enrollee Experience Survey results, also assessing enrollee experiences, were based on a 21% response rate.[51] The results of this survey showed that of the 21% of respondents, only 37% answered "always or usually" to the question about getting information or help from customer service.

These enrollee experience survey results suggest a significant proportion of enrollees do not receive what they perceive to be adequate, knowledgeable or competent assistance when they call the Plan.

Case Examples:

Call inquiry files demonstrated that customer service representatives handling enrollee telephone calls were not consistently knowledgeable and competent regarding enrollee questions and concerns.

LFC 17 #1: The enrollee called the Plan asking for help in finding a substance use disorder provider. The CSR immediately responded by asking: "Did you talk to your doctor?" The enrollee replied he did, and his provider gave him a referral, but when he called the facility to which his PCP referred him, he was told the facility no longer provides SUD services. The CSR told the enrollee she would have to call him back because she was unable to help him and would need to check with the authorization department.

LFC PI #12: The enrollee called the Plan stating his psychiatrist wanted him to see a mental health therapist and asked how he could find one. During the phone call, the

[50] A total of 1,516 surveys were sent to enrollees, with 213 enrollees responding.
[51] A total of 1,690 surveys were sent to enrollees, with 271 enrollees responding.

enrollee stated he was looking at the provider list, but he only saw marriage and family therapists on the list, which was not what he was looking for. The CSR first suggested the enrollee look up the list of providers, then asked whether he called his family doctor for a referral to a psychiatrist. Despite the enrollee explaining he had the list and already had a psychiatrist who told him to contact the Plan to find a therapist, the CSR repeatedly offered to email him the provider list, suggested he call the marriage and family therapist to see "if it is a good fit for you" suggested he show the list to his psychiatrist and finally stated "this is the list we have." The CSR seemed confused about what she was being asked and was unable to help the enrollee find a mental health therapist.

LFC MH #18: The enrollee called the Plan stating her primary care physician sent a referral for a psychologist, but there was some confusion about whether the referral was sent to the Plan or the medical group. The enrollee also inquired whether a referral or authorization was needed, and she was having difficulties getting the appointment with the psychologist. The enrollee stated she made multiple calls to the medical group, the psychologist and the primary care physician trying to determine what the next steps were. She said the psychologist told her an authorization was needed, but her primary care physician told her he sent what he needed to send. The CSR put the enrollee on hold, and when she returned, she told the enrollee her primary care physician needed to send a referral and then the enrollee could see the psychologist. The enrollee reiterated she already called her primary care physician who told her he sent the referral and there was nothing more for him to do. The CSR put the enrollee on hold again and returned to say only a referral was needed. The enrollee explained the situation again and the CSR replied, "But that's what we usually do in the past." The CSR made a call to the psychologist's office, but the office assistant said she would have to return the Plan's phone call. After 38 minutes on the call, the issue was not resolved.

The above examples demonstrate the Plan's customer service representatives were not knowledgeable and competent about the variety of issues and questions raised by enrollees. Customer service representatives overwhelmingly respond to enrollee behavioral health issues and questions with two responses: offering to send a provider list and instructing the enrollee to contact their primary care physician for a referral. Customer service representatives lacked the ability to handle more complex issues and questions.

Conclusion: Review of the Plan's documents, enrollee experience survey results and Inquiry Case Files demonstrated the Plan's customer service representatives are not consistently knowledgeable and competent regarding questions and concerns. Customer service representatives appear to lack sufficient training, are not monitored or evaluated for knowledge and competence, and audio calls demonstrated they were not always able to provide adequate assistance requested by enrollees. The Department therefore finds the Plan in violation of Section 1367.03(a)(10).

#8: The Plan does not have a process for monitoring and evaluating the effectiveness of behavioral health triage and screening services for both non-urgent and urgent services.

Statutory/Regulatory Reference(s): Section 1367.03(a)(8)(A) and (e)(5).

Supporting Documentation:

- 42-040 *Provider Appointment Access Standards* policy and procedure (revised March 2023)
- Post Interview Document Requests sent to the Plan on September 27, 2024

Assessment: Section 1367.03(a)(8)(A) requires health plans to ensure telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and triage or screening waiting time does not exceed 30 minutes.[52]

The Department requested the Plan submit copies of reports, documents and completed tools used to track and evaluate wait times, including triage or screening wait times.[53] In response, the Plan referenced a filing submitted to the Department.[54] That filing contained approximately 35 document submissions, including policies and procedures, a listing of documents filed with the Department and template satisfaction survey tools, among other things. Of the documents filed, the Plan's *Provider Appointment Access Standards* policy states the Plan "ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes."[55] However, none of the documents in the filing were responsive to the request for reports, documents and completed tools used to track and evaluate triage or screening wait times.

On September 27, 2024, the Department sent the Plan several additional document requests. One request asked the Plan to submit a description of how the Plan ensures its triage and screening processes lead to appropriate and timely referrals for both non-urgent and urgent behavioral health care needs.[56] The Plan responded on October 4, 2024, providing the following statement: "CCHP doesn't currently have a specific process or policy that addresses this." The Plan provided no evidence demonstrating it monitors or tracks triage or screening services to ensure compliance with the requirements of Section 1367.03(a)(8)(A).

Conclusion: Based on documents and information submitted by the Plan, the Department found the Plan in violation of Section 1367.03(a)(8)(A) because the Plan was unable to demonstrate it implements and monitors processes to ensure triage or screening services were timely and appropriately delivered to enrollees.[57]

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[52] Triage or screening is the assessment of health concerns and symptoms through communications with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care. (Section 1367.03(e)(5))

[53] Crosswalk sent to the Plan on August 14, 2023, request BHIAA_TA9.

[54] Plan response: "Please see filing number 20230235."

[55] *Provider Appointment Access Standards* policy, page 11.

[56] Request #27 on the CCHP Post Interview Document Requests, submitted to the Plan on September 27, 2024.

[57] The lack of monitoring and evaluation poses a risk to enrollees, as inaccurate or ineffective triage and screening could lead to delays in accessing necessary care, inappropriate level of care assignments, and potentially adverse outcomes.

#9: **The Plan is operating at variance with its filed provider directory policies and procedures.**

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

Supporting Documentation:
- Plan *Provider Directory* policy (revised May 2024)
- 81 Plan Inquiry Files (April 1, 2021, through March 31, 2023)

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 filed amendments or material modification filings.[58]

Included among the types of documents required to be filed are provider directory policies and procedures.[59] Additionally, the Plan filed required annual compliance reports.[60]

As required by Section 1352(a), the Plan filed an amendment with the Department on April 29, 2015 that included the Plan's provider directory policies and procedures.[61] The Plan's *Provider Directory* policy requires the Plan to document receipt of reported potential directory inaccuracies, along with the investigation and outcome, taking no more than 30 business days to verify the accuracy of information each time a report of potential inaccuracy is received.[62] If, as a result of investigation, changes to provider directory information are required, the Plan must make those changes at the next required update.[63] Updates are required the first day of every quarter for the printed provider directory, and monthly or in real-time as needed for the searchable online provider directory.[64] Updates are required within a week when informed of and upon confirmation of certain events, such as a complaint that a provider was not accepting new patients, was otherwise not available or whose contact information was listed incorrectly.[65]

As described in Violation #2, review of inquiry files demonstrated that when enrollees reported potential provider directory inaccuracies by stating a provider was not accepting new patients, the provider was not available or other potential inaccuracies, there is no evidence the Plan documented, investigated or determined an outcome of the potential inaccuracy, or made changes to the provider directory when an inaccuracy was confirmed, as required by the *Plan's Provider Directory* policy.

Conclusion: The Plan's customer service representatives do not consistently identify, document and submit for handling potential provider directory inaccuracies reported by

[58] Sections 1386(b)(1), 1351, 1352.
[59] Section 1367.27(m)(1).
[60] See, i.e., eFiling #s 20171727, 20181140, 20221828, 20230235, 20234082, 20242226.
[61] See eFiling #20151059.
[62] *Provider Directory* policy, page 3.
[63] *Provider Directory* policy, page 3.
[64] *Provider Directory* policy, page 3.
[65] *Provider Directory* policy, page 3.

enrollees. By failing to document, investigate and determine whether potential provider directory inaccuracies required changes to the provider directory, the Plan is operating at variance with its filed *Provider Directory* policy, in violation of Section 1386(b)(1).

#10: **The Plan is operating at variance with its filed *Provider Appointment Access Standards* policy.**

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

Supporting Documentation:

- 42-040 *Provider Appointment Access Standards* policy and procedure (revised March 2023)

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 filed amendments or material modification filings.[66]

Included among the types of documents required to be filed are quality assurance policies and procedures.[67] In addition, as part of written quality assurance systems, plans must file compliance monitoring policies and procedures designed to accurately measure accessibility, which shall include tracking and documenting capacity with respect to timely access standards, including triage and screening wait times.[68]

On January 16, 2023, pursuant to Section 1352(a) and timely access reporting requirements, the Plan filed an amendment with the Department in eFiling 20230235. As part of the amendment, the Plan filed the *Provider Appointment Access Standards* policy and procedure. As described in Violation # 6, the *Provider Appointment Access Standards* policy states the Plan "ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes."[69] However, the Plan was unable to provide any reports, documents or completed tools used to track and evaluate triage or screening wait times. Further, the Plan stated it did not have a process in place to ensure triage and screening processes resulted in appropriate and timely referrals for both non-urgent and urgent behavioral health care needs, as required by its policy.

Conclusion: Because the Plan was unable to demonstrate it has a process to ensure triage and screening services are provided in a timely manner not to exceed 30 minutes, as required by the Plan's policy, the Plan was operating at variance with its filed *Provider Appointment Access Standards* policy, in violation of Section 1386(b)(1).

[66] Sections 1386(b)(1), 1351, 1352.
[67] Section 1351(m).
[68] Rules 1300.67.2.2(c)(8)(A), 1300.67.2.2(d)(2)(A)(i).
[69] *Provider Appointment Access Standards* policy, page 11.

GRIEVANCES AND APPEALS

#11: **The Plan does not consistently identify oral expressions of dissatisfaction as grievances.**

Statutory/Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(1)

Supporting Documentation:

- Plan policy 70-001 *Receipt, Resolution and Documentation of Member Inquiries* (August 1, 2024)
- *Member Services Workflow for Customer Inquiries* (undated)
- 81 Plan Inquiry Files (April 1, 2021 through March 31, 2023)

Assessment: Health plan grievance systems must have "reasonable procedures in accordance with Department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate."[70] Regulations define "grievance" 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 reconsider or appeal made by an enrollee or the enrollee's representative.[71]

In addition, when a health plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[72]

Policies, Procedures and Training Documents

The Plan's *Receipt, Resolution and Documentation of Member Inquiries* policy includes a definition of grievance that tracks the definition in Rule 1300.68(a)(1) and includes an "oral expression of dissatisfaction." The policy further states that if there is a question "as to whether an issue is an inquiry or a grievance, the question should be referred to the member Services Manager for a decision" and may include consultation with the Quality Assessment Manager.[73] If management "is unable to distinguish between an inquiry or a grievance, it will be considered a grievance." Calls that include a grievance are to be documented by the CSR and sent to the Grievance and Appeal Coordinator (for standard grievances) or categorized as "EXG" if the grievance is exempt and subject to Section 1368(a)(4)(B), with notes documenting the nature of the enrollee's grievance.[74] Therefore, if an enrollee calls the Plan and makes an expression of dissatisfaction, or if

[70] Section 1368(a)(1).
[71] Rule 1300.68(a)(1).
[72] Rule 1300.68(a)(1).
[73] *Receipt, Resolution and Documentation of Member Inquiries* policy, page 2.
[74] *See Receipt, Resolution and Documentation of Member Inquiries* policy, page 3 under "Logging an Exempt Grievance." Section 1386(a)(4)(B) exempts plans from having to send acknowledgment and resolution letters to enrollees for grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

management cannot determine whether the call is an inquiry or a grievance, a grievance should be documented and handled as required.

The Plan also submitted documents in response to a request for training materials, job aids and scripts used by Plan and/or delegate customer service staff in the event an enrollee expresses dissatisfaction with the Plan/Delegate and/or Plan services.[75] Of the four documents submitted, only one, a one-page document titled *Member Services Workflow for Customer Inquiries*, mentioned grievances or handling of expressions of dissatisfaction. This document indicates that when an inbound communication from an enrollee contains an expression of dissatisfaction, the CSR either: (1) provides a solution within the next business day "if not related to a dispute or treatment etc." and files it as an exempt grievance, documenting on Meditrac, or (2) assists the enrollee to file an appeal or a grievance, routing it to the Appeal and Grievance Department.

File Review

The Department reviewed 81 call inquiry audio files involving behavioral health issues, including audio recordings of the calls. The Department determined 17[76] of the files (19%) involved an oral expression of dissatisfaction. The Department found no evidence in the files demonstrating the Plan processed them as grievances as required by Section 1368(a)(1).

Case Examples

- **Inquiry File LFC MH #8:** The enrollee's parent contacted the Plan and stated the enrollee's school needed a letter from the treating psychiatrist. The parent stated the psychiatrist was requesting $400.00 to write the letter for the request. The parent exhibited dissatisfaction on the call and the CSR asked if the parent wanted to file a grievance. When the parent replied "no," the CSR did not file a grievance.
- **Inquiry File LFC MH #14:** The enrollee called and presented as emotional and stressed. The enrollee was upset their PCP had not sent the treating psychiatrist the enrollee's medical records even after several requests were made. The CSR did not file a grievance.
- **Inquiry File LFC PI #12:** The enrollee called the Plan and stated their psychiatrist wanted them to see a therapist. Enrollee expressed dissatisfaction and frustration with the Plan's provider online directory and the psychiatrist's lack of knowledge of the Plan's referral process. The CSR did not file a grievance.

None of the files listed above included documentation identifying the expressions of dissatisfaction as exempt or other grievances, or any handling of the issues as grievances.

[75] Crosswalk request BHICS7.
[76] Plan Inquiry Files: LFC_MH Audio Files: 8, 10, 14, 18; LFC PI Audio Files: 8, 12, 15, 16, 26, 35, 45; LFC_17 Audio Files: 1, 3, 4, 7, 11, 15.

Interviews

The Department interviewed one of the Plan's CSRs and asked how CSRs are trained to identify grievances. The CSR responded that training is provided, and satisfaction is identified based on the caller's tone of voice. The Department asked how the CSR responds when a caller's tone expresses dissatisfaction. The CSR stated they try to identify the issue and offer to file a grievance. She also said if they cannot resolve the issue the same day, then a grievance is submitted. If the enrollee states they do not want to file a grievance when prompted by the CSR, she stated "a grievance would not be filed."

None of the training or other documents submitted by the Plan indicate CSRs receive daily training on identification or handling of calls involving grievances. Although the CSRs tried to assist enrollees during calls, the inquiry files demonstrate that grievances were not identified, documented or referred as required.

TABLE 2

Inquiry file review: oral expressions of dissatisfaction

FILE TYPE	NUMBER OF FILES	LEGAL REQUIREMENT	COMPLIANT	DEFICIENT
Plan Inquiry Files	81	Identify oral expressions of dissatisfaction as grievances	72 (81%)	17 (19%)

Conclusion: Based on review of Plan documents, inquiry audio files, and information obtained during interviews, the Department determined the Plan did not consistently identify grievances in calls received from enrollees as required by Section 1368(a)(1) and Rule 1300.68(a)(1). Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

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

The following is an overview of the barriers to care the Department identified through its investigation of the Plan. Additional information on the barriers will be included in the Department's Phase Three 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 care. 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.

The barriers themselves may not arise to a violation of the Knox-Keene Act and/or Rules. The barriers may be caused by a combination of factors, such as a lack of certain provider types due to market conditions (i.e., supply of providers has not kept up with demand for services), health plan acts or omissions that do not arise to a violation of the Knox-Keene Act and/or Rules, circumstances that may not be covered by the Knox-Keene Act and/or Rules, or insufficient facts to support a finding of a violation of the Knox-Keene Act. Although barriers are not enforceable under the Knox-Keene Act, the Summary Report for each phase of the BHIs will include recommendations to reduce barriers and improve access to behavioral health services.

#1: **The Plan does not provide enrollees with sufficient messaging about how to access behavioral health services, and enrollees experience difficulties when trying to obtain behavioral health services.**

Summary: Enrollee understanding of the process for obtaining behavioral health services is a critical step in finding a provider. The Plan stated enrollees are provided information about how to access behavioral health services via the Plan's Evidence of Coverage (EOC) and the Plan's website.[77]

The EOC covers behavioral health care on pages 67-73, describing coverage, exclusions and descriptions of behavioral health care, but does not describe the process for accessing services. The section of the EOC on Accessing Care of Physicians and Providers states on page 32 "Your Primary Care Physician will . . . coordinate all your medical care. You must have a referral from your Primary Care Physician for most medical care…." On page 36, under Referral to Specialists, the EOC states "The Primary Care Physician you have selected will coordinate all of your health care needs. If your Primary Care Physician determines you need to see a specialist, he or she will make an appropriate specialist referral. Your Primary Care Physician will determine the number of specialist visits that you require and will provide you with any other special instructions."

It may not be clear to enrollees from the above language that therapists, psychologists, ABA providers, substance use disorder counselors, residential services and other

[77] Plan response to Crosswalk request BHIAA_TA15.

behavioral health providers are “specialists” requiring a referral. Additionally, with the information spread across different parts of the EOC, it may be difficult for an enrollee to find the needed information.

The Plan’s website has a “Find a Doctor” button on the homepage, but there is no indication how the enrollee should search for a non-physician behavioral health provider. When clicking the “Find a Doctor” button, the enrollee may then select from “Search by Doctor Type,” “Search by Doctor Name,” Search by Hospital/Facility” or “Search by NPI.” Again, these options may not be sufficient to provide enrollees with information for finding non-physician behavioral health providers. If the enrollee selects “Search by Doctor Type” the default doctor type is “Primary Care Physician,” otherwise the enrollee may select “Specialty.” The enrollee must then access the Specialty alphabetic dropdown list, scrolling to choose Addiction, Addiction Medicine, Behavior Analyst, Psychiatry, Psychologist or Social Worker. The enrollee must also know their plan type (i.e., individual and family plans or Covered California plans) as well as the applicable medical group for the services they are seeking. In some instances, an enrollee who is enrolled in Hills Physicians Medical Group must use Jade Medical Group behavioral health providers. This distinction, and navigating the website, may not always clear to enrollees.

Call inquiry files demonstrated many instances of enrollee confusion about how to obtain services and differentiating between a referral and a prior authorization.[78]

Case Examples

- **Inquiry File LFC17 #11**: The enrollee called to check on a prior authorization request for therapy and said the medical group had not yet received the prior authorization. The CSR explained the medical group is not responsible for reviewing the prior authorization and confirmed the Plan had the authorizations on file.

- **Inquiry File LFC17 #15**: The enrollee called to ask how to get a psychiatry visit as they understood they needed a prior authorization. The CSR explained the enrollee needed only a referral from their PCP.

- **Inquiry File LFC_PI #3**: The enrollee, a member of Hill Physicians Medical Group, called to inquire about a referral for a psychiatry provider and whether the referred provider was part of Hill Physicians Medical Group. The CSR informed the enrollee “Hill does not have psychiatrists. Psychiatrists must be from Jade.” The enrollee expressed confusion about the process and coverage information received when they called the provider. The CSR explained how the referral process works and notified the behavioral health provider of the process as well.

- **Inquiry Files LFC_PI #14, #15**: The enrollee called looking for a therapist as they were having trouble locating one. Customer Service emailed them a list and then

[78] Plan Inquiry Files: LFC17 Files 2, 4, 6, 10, 11, 15; LFC_PI Files 3, 4, 5, 13, 14, 15, 19, 24, 27, 28, 37, 41, 42, 43, 50; LFC_MH Files 3, 4, 6, 12, 13, 15, 16, 18, 21.

informed the enrollee a referral was needed. The enrollee called again the same day stating they were unclear what to do with the list and what the process is. Customer service again informed the enrollee a referral was needed from the enrollee's PCP.

- **Inquiry File LFC_PI #28**: The enrollee called to get a behavioral health appointment and stated the website was very confusing and the enrollee was not sure whether the provider they found on the website was in network.

- **Inquiry File LFC_PI #41**: The enrollee called and said their PCP told them no behavioral health providers in the medical provider group are accepting new patients. The CSR told the enrollee they should use providers in the behavioral health provider group, not the medical provider group. The CSR offered to email a list of providers to the enrollee.

- **Inquiry Files LFC_MH #3, #4, #6, #12, #13, #15, #18, #21**: These individual enrollees called the Plan asking how to obtain behavioral health services, how to get a behavioral health appointment, where to find a list of behavioral health providers, or whether a referral was needed.

Based on information provided by the Plan about how the Plan informs enrollees of the process to obtain behavioral health services, and review of Customer Inquiry files, the Department found enrollees experience confusion and sometimes receive misinformation about how to obtain behavioral health services.

#2: The Plan's requirement for enrollees to obtain a PCP referral for behavioral health services may delay or present a barrier to timely access to services.

Summary: The Plan requires enrollees to obtain a referral from their primary care physician (PCP) in order to receive behavioral health services that do not require prior authorization, such as therapy and psychiatry services.[79]

During interviews, the Plan's Medical Director confirmed that utilization management is not conducted on behavioral health referrals received from PCPs. The Medical Director stated the purpose of documenting the referral is "to exercise some modicum of control over the services" including, for example, alerting the UM department if an enrollee needs case management so the matter can be referred to a case manager for work up. This way, the Plan explained, the Plan's internal management team can be aware of a patient that may need extra services. However, the Plan's utilization management nurse responsible for reviewing behavioral health service requests stated during interviews she did not know where PCP referrals were documented in the Plan's system, and she was not aware of how referrals were monitored or tracked. No evidence was offered to explain who reviewed, documented, tracked or monitored PCP referrals for behavioral

[79] See the Plan's *Specialist Referrals* policy, which states "Members may require medically necessary services that go beyond the scope of their PCP. When this occurs, the PCP refers the member to an appropriate CCHP participating specialist." The policy also states: "When a CCHP PCP identifies the need for a referral, the PCP may refer members to CCHP specialist physicians, including behavioral health specialists as medically necessary. After the four visits, health plan authorization must be obtained."

health services. Additionally, the Medical Director confirmed that if an enrollee directly made a behavioral health appointment without getting a referral and received services, the Plan would likely pay the claim, indicating there is no operational, clinical or other justification for requiring referrals for behavioral health services that are not subject to prior authorization.

Call inquiry files confirmed when enrollees call the Plan seeking behavioral health services, CSRs inform enrollees they must get a referral from the PCP.

Case Examples

- **Inquiry File LFC_PI #10:** The enrollee called seeking an appointment with a psychiatrist for their child. After verifying the enrollee's membership information, the CSR asked, "Have you told your family doctor?" When the enrollee confirmed they spoke with their PCP, the CSR stated that psychiatry requires a doctor's referral. The CSR further stated they would send the enrollee a provider list and then instructed the enrollee to call the provider to see whether they can book an appointment and "[a]fter they have booked you in, you will need to call your doctor for a referral letter."
- **Inquiry File LFC_PI #52:** The enrollee called the Plan asking, "do you have a list of psychologists?" The CSR emailed a list of providers to the enrollee and stated, "After you review [the list] you need to tell your family doctor to write a referral letter." The enrollee asked "Oh, I need to tell my family doctor as well?" The CSR stated, "It is a must." When the enrollee began to ask, "Can I directly…" the CSR interrupted and said "No, you can't as HMO plan always need a referral letter of [sic] doctor."
- **Inquiry File LFC_MH #13:** The enrollee called wanting to find a mental health therapist. After verifying the enrollee's membership, the CSR offered to email a provider list to the enrollee. The enrollee agreed and the CSR then stated a referral from the enrollee's PCP is required for a mental health visit. The enrollee asked how they might best get the referral and whether they should message their doctor. The CSR stated, "I advise you to call support health services to make an appointment with [your] PCP."

Requiring enrollees to obtain PCP referrals prior to accessing behavioral health services such as therapy appointments and other behavioral health services that do not require prior authorization, can be a roadblock serving to delay services. Enrollees who could otherwise directly schedule and obtain behavioral health services, are instructed by CSRs to go to their PCP for a referral. Enrollees who are deterred or delayed from contacting their PCP for a referral may not follow up, which could result in the enrollee not receiving needed services.

#3: The Plan does not have a system to track customer service calls for repeat callers to identify trends, patterns or problems.

Summary: The Department requested documentation of the Plan's tracking of repeat callers and instances of when an enrollee contacted the Plan more than once for the

same behavioral health issue.[80] The Plan's submitted customer service work flows, desk aids and policies and procedures included no description of a process for tracking or reporting on instances in which a caller makes more than one call to resolve a concern ("repeat callers").[81] The Plan's *Receipt, Resolution and Documentation of Member Inquiries* policy states on page 5 that when another Plan department receives a request from Member Services to follow up on an enrollee inquiry, the department "will take steps necessary to complete the process required to solve the inquiry, thereby eliminating further inquiries from the member." However, the Plan has no process to monitor or track further enrollee inquiries or calls concerning the same issue or problem.

During interviews, the Plan's Director of Customer Service stated the Plan did not have a process during the review period to track the frequency or dates of contact by enrollees making repeated attempts to make behavioral health appointments. The Director of Customer Service stated that the Plan recently initiated a tracking process. As a result of not having a process to track repeat callers, the Plan is not able to monitor instances in which callers are not getting the assistance they require and therefore cannot fully evaluate the effectiveness of customer service operations. Moreover, enrollees who call repeatedly and fail to get the assistance they need may be unable to obtain timely, appropriate health care services.

#4: <u>The Plan lacks processes for ensuring delivery of culturally competent behavioral health care as well as monitoring and addressing disparities among the enrollee population.</u>

The Department requested the Plan submit a number of documents pertaining to cultural competency. Among the documents requested were:

- Policies, procedures and processes used to address cultural competence related to the delivery of behavioral health services.
- Cultural competence training provided to providers and Plan staff.
- A description of the oversight and monitoring of contracted providers to ensure providers meet cultural needs and preferences of its membership.
- Documents describing the Plan's community outreach and engagement with racial, cultural, linguistic and other communities.
- Documents describing how the Plan identifies disparities and measures and monitors strategies for addressing disparities across its enrollee population related to accessing behavioral health services, including disparities related to age, sex, race, culture, religion, language, disability, ethnicity, gender, LGBTQ, income level and geographic location.[82]

In response to each of these requests, the Plan submitted the following statement:

[80] Crosswalk request BHICS13.
[81] Crosswalk BHICS7 Job Aids, CCHP UCCX Member Services Call Flow, Interactive Voice Response, Member Services operation chart relation to Grievance, Operational Chart relation to UM; Plan policy *Receipt, Resolution and Documentation of Member Inquiries*.
[82] Crosswalk requests BHIHEC1-BHIHEC8.

> CCHP is currently in the process of going through the National Committee for Quality Assurance (NCQA) for Health Equity Accreditation. We are currently developing the documents to address this requirement.

No other responsive documents were provided. Lack of processes to ensure Plan staff and providers deliver services in a culturally competent manner, and lack of systems designed to identify, monitor and address disparities among the enrollee population may result in barriers to appropriate, effective behavioral health care.

#5: **Neither the Plan nor its Pharmacy Benefit Manager has a process to assist enrollees with reminders for medication compliance.**

Summary: Enrollees who have high-risk behavioral health conditions can suffer potentially serious and dangerous impacts to their mental health if they become noncompliant with medication requirements. Any struggle or barriers to obtaining prescription drugs timely and conveniently may cause an enrollee with a high-risk behavioral health condition to interrupt or discontinue important medication. Missed doses or discontinued medications may result in exacerbation of symptoms and damaging behavior, either to self or to others.

Pharmacy refill protocols often include a process for denying medication refills when a refill is requested prior to the expected calendar refill date. For safety reasons, only specific amounts or quantities of medication may be covered in a certain period of time. These quantity limits vary for different medications. Timely reminders sent to enrollees when it is time to refill medication could prevent missed medication or noncompliance. Just as some plans have a process in place to remind enrollees when certain procedures are due, such as a mammogram or colonoscopy, reminders for critical behavioral health medications could help ensure medication compliance. Encouraging enrollees to remain stable on their appropriate medication is a critical component to behavioral health care in high-risk enrollees.

During interviews, the Plan and its Pharmacy Benefit Manager were asked about medication reminders for high-risk enrollees. Neither were aware of any process in place for the Plan or Pharmacy Benefit Manager to provide reminder assistance for enrollees with a behavioral health condition.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified eleven Knox-Keene Act violations and five barriers to care not based on Knox-Keene Act requirements.

Within 10 business days of issuance of this Report, the Plan is required to notify the Department in writing of any ***factual*** errors in the Report (Response). The Plan's Response shall include all of the following:

- A detailed explanation of the Plan's perceived factual error (factual errors include, for example, a misspelled policy name, incorrectly cited document date, etc.).
- Documentation necessary to demonstrate the factual error and the Plan's asserted correct fact(s) (correct facts may be demonstrated by submission of relevant documentation, for example, the title page with correct policy name, document page with correct date, etc.). Please highlight relevant correct information in the documentation submitted to ensure the Department is able to identify and confirm the correct fact.

Information in the Plan's Response that goes beyond the identification of factual errors will not be considered for purposes of this Report.

Within 30 calendar days from issuance of this Report, the Plan is required to submit a corrective action plan (CAP) that is reasonably calculated to correct the eleven identified Knox-Keene Act violations.

The Plan may submit a statement describing actions the Plan has or will take to address the five 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 May 12, 2025, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, and CAP 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 2024 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
Jennifer Sharifi	Attorney III
Owen Zion	Attorney III
Oksana Meyer	Staff Services Manager III, Plan Surveys Chief
Kimberly Galli	Staff Services Manager II, BHI Manager
Michele Bogue	Health Program Specialist II, Team Lead

CONSULTANT TEAM MEMBERS: MAXIMUS FEDERAL SERVICES, INC.

Kathleen Lockwood	Project Manager
Dr. Beverly Grimshaw	Investigator
Andrew Mendonsa	Investigator
Alessandra Beers	Investigator
Martha Crowley	Investigator
Carol Brooke	(Observer)
Julie Morgan	(Observer)

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CHINESE COMMUNITY HEALTH PLAN DBA BALANCE BY CCHP

Larry Loo	Chief Executive Officer
Dr. Craig Reich	Chief Medical Officer
Ken Choi	Chief Financial Officer
Ketan Gema	Chief Operating Officer
Rocio Cortez	Director of Population Health Management
Grace Huang	UM Project and Data Specialist
Dee Johnson	Claims Director
Rebecca Talley	Contracting Director
Sonya Soder	Member Services
Gordon Hung	Provider Relations and Network Manager
Derrick Ho	Compliance Specialist
Diana Chen	Compliance Specialist
Michael Tran	Compliance Analyst
Janet Eisenberg	CO/Director of Compliance
Mary Zhang	Pharm.D., Pharmacy Manager
Michael Zeng	Clinical Pharmacist Lead/Operations Resource Support/Pharmacy Consultant
Kathy Saechao	Quality Improvement Specialist
Kathleen Smith	Lead Utilization Review Nurse
Vivian Yu	Appeals & Grievances Specialist

DELEGATE STAFF INTERVIEWED FROM: MEDIMPACT, PHARMACY BENEFIT MANAGER

Krista Ouellette	Prior Authorization Audit Pharmacist
Bryan Donlevy	Vice President, Financial Strategic Outcomes
Peter Martina	Principal Pricing and Analytics
Ruby Johnston	External Compliance Support Manager

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	Number of Files	File ID Number
Plan Inquiry Files LFC_17	17	FL0210660 FL0215401 FL0216223 FL0215401 FL0234910 FL0285044 FL0293806 FL0300531 FL0313198 FL0338340 FL0343909 FL0344252 FL0351316 FL0356485 FL0357536 FL0377206 FL0377206
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Plan Inquiry Files LFC_PI	56	FL0181530 FL0188045 FL0188680 FL0198966 FL0202015 FL0204264 FL0207135 FL0210660 FL0216267 FL0218291 FL0223295 FL0223647 FL0227173 FL0234315 FL0234315 FL0234910 FL0235168 FL0236666 FL0237101 FL0238626 FL0238626 FL0244420

Type of Case Files Reviewed	Number of Files	File ID Number
Plan Inquiry Files LFC_PI (continued)		FL0247791 FL0266834 FL0269253 FL0273389 FL0281386 FL0286577 FL0286621 FL0296801 FL0309751 FL0312388 FL0321101 FL0321826 FL0325368 FL0326208 FL0326493 FL0342357 FL0350469 FL0351316 FL0352736 FL0354210 FL0356485 FL0358072 FL0358387 FL0363508 FL0377198 FL0377206 FL0377206 FL0380299 FL0383499 FL0383640 FL0388072 FL0388072 FL0388297 FL0389233

Type of Case Files Reviewed	Number of Files	File ID Number
Plan Inquiry Files LFC_MH	21	FL0182516 FL0211399 FL0212429 FL0215424 FL0216715 FL0222015 FL0232524 FL0267542 FL0285044 FL0289113 FL0300531 FL0306142 FL0324400 FL0337184 FL0338340 FL0344252 FL0345943 FL0357536 FL0358113 FL0362296 FL0376550
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Utilization Management LFA_40	25	49505 50457 50462 50706 52104 55604 55944 55972 56652 56672 58273 58290 59235 59527 59560 63830 64424 68853 69141 69227 69311

Type of Case Files Reviewed	Number of Files	File ID Number
Utilization Management LFA_40 (continued)		69340 69602 70118 70345
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Utilization Management LFA_SB	55	57778 69779 69911 62046 58290 69779 63830 69964 69779 58273 62046 62380 69602 69963 55531 67726 67726 57186 70131 66918 69649 69612 70304 69649 59235 59711 69577 64672 64672 69814 59381 56672 62705 69988 70118

Type of Case Files Reviewed	Number of Files	File ID Number
Utilization Management LFA_SB (continued)		69577 70280 56652 70131 69754 69649 70304 69351 64025 53634 69862 70118 63903 64486 69965 60391 70367 59560 69311 58324
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Benefit/Coverage/Experimental Denials of Behavioral Health Services LFB	51	0001326799 0001331461 0001361047 0001364494 0001364495 0001364496 0001368190 0001374587 0001439475 0001448648 0001460220 0001496109 0001505033 0001510308 0001510804 0001515308 0001588412 0001603810 0001603811 0001624974

Type of Case Files Reviewed	Number of Files	File ID Number
Benefit/Coverage/Experimental Denials of Behavioral Health Services LFB (continued)		0001644980 0001725175 0001767149 0001769549 0001773094 0001797295 0001797296 0001797349 0001828907 0001829517 0001831371 0001835261 0001887709 0001887710 0002646052 0002871496 0002872186 0002888843 0002916018 0002921537 0002921538 0002926903 0002943822 0002943823 0002943824 0002943825 0002947084 0002948459 0002948460 0002948461 0003020703

Type of Case Files Reviewed	Number of Files	File ID Number
Provider Complaints LFE	32	29046 29047 29153 29154 29157 29181 29182 29183 29219 31032 31097 31161 31421 31422 32775 32776 32777 41096 42134 44164 45203 45204 51352 51353 56715 61826 61844 61845 62845 62911 66868 77089

Type of Case Files Reviewed	Number of Files	File ID Number
Denied Claims for Behavioral Health Services LFH	54	0001326799 0001331461 0001361047 0001364494 0001364495 0001364496 0001368190 0001374587 0001439475 0001448648 0001460220 0001460797 0001496109 0001500212 0001505033 0001510308 0001510804 0001515308 0001564600 0001588412 0001603810 0001603811 0001624974 0001644980 0001725175 0001769549 0001773094 0001797295 0001797296 0001797349 0001828907 0001829517 0001831371 0001835261 0001887709

Type of Case Files Reviewed	Number of Files	File ID Number
Denied Claims for Behavioral Health Services LFH (continued)		0001887710 0002646052 0002866735 0002871496 0002872186 0002888843 0002916018 0002921537 0002921538 0002926903 0002943822 0002943823 0002943824 0002943825 0002947084 0002948459 0002948460 0002948461 0003020703
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Requests for out of network coverage LFM	8	FL0198327 FL0237101 FL0243112 FL0246321 FL0264792 FL0306583 FL0325368 FL0326493

Type of Case Files Reviewed	Number of Files	File ID Number
Utilization Review (MedImpact) LFA_CCHP	14	026769-00 000795-00 104308-00 000795-00 002461-00 002604-00 104234-00 104234-00 006305-00 028370-00 027488-00 025463-00 028212-00 028212-00
Type of Case Files Reviewed	**Number of Files**	**File ID Number**
Behavioral Health Emergency Services LFJ	7	0001363171 0001379466 0001414404 0001439840 0001453772 0001466935 0002871497

Chinese Community Health Plan
Corrective Action Plan Response

CCHP Health Plan
445 Grant Avenue, Suite 700 | San Francisco, CA 94108
T 1-415-955-8800 | F 1-415-955-8818 | www.CCHPHealthPlan.com

DMHC Behavioral Health Investigation Balance by CCHP – Dated April 11, 2025
CCHP Corrective Action Plan (CAP)

Section 1: DMHC Findings

I. APPOINTMENT AVAILABILITY AND TIMELY ACCESS

Finding#1 [QI]: The Plan's appointment accessibility monitoring is insufficient to ensure compliance with timely access standards.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
Due to small sample size, Provider Appointment Availability Survey (PAAS) surveys are not the most adequate source to track appointment accessibility	✓ By monitoring Member Services calls and Grievances from members, the Health Plan identifies the needs of BH/MH services ✓ The CCHP QI Department will collaborate with Provider Network Management (PNM) Department to provide oversight on Hill Physician Medical Group/HPMG (delegate) to ensure their providers are aware of timely access standards, that HPMG is in CCHP's network, and obligation to participate in QI activities, which include regulatory surveys. ✓ CCHP will implement a report to identify MH/BH utilization (Claims) and compare data with providers in network offering BH/MH services to ensure capacity.	✓ In place effective 2024. ✓ Communications to HPMG in Q3 2025 and Q4 2025 prior to MY2025 PAAS survey administration. ✓ Effective June – July 2025
In 2021 and 2022, the plan did not have a BH/MH category to identify Grievances as such.	Effective in 2024, CCHP added a custom attribute in Meditrac to all Grievance and Appeal (G&A) cases to identify any and every Behavioral Health/Mental Health-related cases. (see attachment).	In place effective 3/20/2024. See document: *Exhibit#1 BH_MH GA case category*

Finding #2 [MS]: The Plan does not have a process to ensure enrollees who call the Plan or submit grievances about BH appointment requests are offered appointments that meet timely access standards.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
CCHP was offering BH appointment support to members, however not documented properly in P&P	✓ Commercial GA P&P 42-GA003 has been updated reflecting new process to offer BH appointments aligned with Timely Access requirements (see attachment BHI 2 42-GA003 Commercial GA_Edits 4.30).	✓ Completed April 30, 2025. ✓ Completed May 7, 2025. ✓ Completed May 7, 2025.

and workflows are not delineated accordingly.	✓ CCHP has established a formal workflow to ensure appointments are offered to members upon submitting grievance. The Process includes 3 levels: A) MS conference calling BH provider B) If MS fails to obtain an appointment, the case is immediately escalated to Utilization Management (UM) C) If UM fails to get an appointment, the case is escalated to Provider Network and Contracting. ✓ Training on new workflow and Timely Access Standards (see attachment Exhibit#2 BH_MH GA case category)	See documents: ✓ *BHI 2 42-GA003 Commercial GA_Edits 4.30* ✓ *Exhibit#2 _Grievance on BH and finding #2 Training*
Absence of a standardized process and clear protocols for handling BH access-related calls and grievances.	Develop protocols for managing BH appointment-related calls and grievances, incorporate clear timelines and responsibilities in alignment with timely access standards. (Desktop procedure for handling BH Appointment-Related Calls and Grievances.	See attached document: *Desktop Policy for Handling BH Appointment-Related Calls and Grievances*
Inadequate staff training on timely access requirements, including recognizing expressions of dissatisfaction such as grievances and appointment requests.	Provide refresher training to customer service staff on identifying and addressing BH access and grievance issues, including clear escalation procedures for urgent access needs.	Target Date of Completion: 6/30/2025.

Finding #3 [PNM]: The Plan fails to consistently identify, investigate and document potential provider directory inaccuracies reported to member services.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
No existing processes nor documentation for member reported provider directory inaccuracies. Existing informal policy for member reported inaccuracies is for ad hoc resolution via internal phone calls.	✓ CCHP developed/established a desk level procedure between Member Services and Provider Network Management to document actions and processes of member reported directory inaccuracies. ✓ Actions will be logged in CCHP's database, MediTrac, as workflow events. ✓ Monthly reports to be requested from MediTrac to be submitted to Provider Network Management manager and Member Services manager.	▪ Desk level procedure to be completed 5/22/2024. ○ See document: *Agreement - Member Request for Provider Directory Updates (Member Services & PNM) 5-22-24* ▪ The capability to log actions in MediTrac completed 7/26/2024. ○ See document: *PNM Workflows with Workgroup.xls* ▪ Monthly report to managers to be completed by 9/1/2025.

Finding #4 [PNM]: The Plan does not monitor network adequacy, including timely and geographic accessibility, for Pervasive Developmental Disorder and autism services.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
CCHP's current network adequacy software package for Quest Analytics does not account for DMHC specialties such as Pervasive Developmental Disorder and autism services.	CCHP to continue internal discussion in regard to acquiring software that would capture DMHC required specialties such as Pervasive Developmental Disorder and autism services. Existing network submissions for service area expansion, such as the recent DMHC Service Area Expansion request for Alameda County to be used as reference for gaps in CCHP's network. Additionally, CCHP's monthly network development meeting to use clinical observations of gaps for behavioral and mental health providers. CCHP also leverages the Timely Access and Annual Network (Annual) submissions Findings and Corrective Actions as additional methods in reviewing / assessing CCHP Network Adequacy. CCHP notes that its current service area expansion application for Alameda County includes its current approved-service areas of San Francisco and San Mateo.	To be completed by 9/1/2025.

II. UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

Finding #5[PNM]: The Plan does not timely notify behavioral health provider applicants of the status of their credentialing application.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
CCHP does not have a policy in its credentialing department to require notifying applicants of their credentialing application statuses. Additionally, there is no desktop procedures for credentialing staff to review nor	CCHP to update/create credentialing policies that affirm timeframes for notifying credentialing applicants of their application status. CCHP to create desktop procedures for staff to review and resolve credentialing applications.	▪ Updated/Created credentialing policies drafted 3/27/2025. ○ See document: *12-PNM 12-003A Program - Credentialing Program 3-27-2025* ▪ Credentialing desktop procedures drafted 8/30/2024.

complete credentialing applications.		○ See documents: *Credentialing Facilities* and *Credentialing Initial Credentialing Guide.*

III. QUALITY ASSURANCE

Finding #6 [UM]: The Plan's Maternal Mental Health program does not include quality measures to encourage screening, diagnosis, treatment and referral.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
The 2024 program lacked the process to evaluate the effectiveness of the Maternal Mental Health Program.	The 2025 Maternal Mental Health Program includes a process for evaluating the program's effectiveness and formal communication informing primary care and OBGYN providers about the new standard. Please see the revised 2025 program and letter.	See Document: *41-UM-ADMIN 922 Maternal_Mental_Health_Screening_Pregnancy_Postpartum_redlined 3.20.2025.4.29.25* See Document: *maternal mental health letter to providers*
CCHP's online provider directory did not have the ability to search for behavioral health providers by specialty.	The CCHP online provider directory, accessible to members and providers, is undergoing a user interface feature update that will increase the accessibility of mental and behavioral health providers by external individuals. These features will allow members and providers to adequately search for mental and behavioral health providers.	To be completed by June 30, 2025.

Finding #7 [MS]: Customer Service Representatives are not consistently knowledgeable and competent regarding enrollee questions and concerns.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
Insufficient frequency of training and knowledge assessments has resulted in gaps in staff knowledge and overall competence.	✓ Implement quarterly refresher training sessions for CSRs, including knowledge tests to evaluate their understanding and competency on various topics in inquiries. ✓ Provide CSRs with training focused on answering member inquiries within 10 minutes, ensuring efficiency and accurate responses. ✓ Conduct quarterly reviews of about 18 randomly selected calls per representative to assess accuracy, compliance, customer service quality, and adherence to protocols.	Target date of completion: 6/30/2025.

Lack of a streamlined process for accessing BH visits and unclear provider network structure due to carved-out mental health benefit.	Effective immediately, referrals and authorizations are no longer required for in-network mental and behavioral health providers. Members may now (self) refer to any in-network BH provider without prior approval.	Effective 4/30/2025.
Absence of standardized processes and clear protocols for handling BH access-related calls and grievances.	Create a Desktop procedure for handling BH Appointment-Related Calls and Grievances.	Target Date of Completion: 6/30/2025.

Finding #8 [MS]: The Plan does not have a process for monitoring and evaluating the effectiveness of behavioral health triage and screening services for both non-urgent and urgent services.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
UM AUTH 200 Response Times Policy does not address the management of prior authorization requests for behavioral health care.	UM AUTH 200 **was revised** to address the management of prior authorization requests for behavioral health care.	Utilization Management Committee review for UM AUTH 200 at 6/2025 Committee meeting. See documents: • *41-UM-AUTH 200 Response Timeframes 5.15.2025* • *41-UM-AUTH 200 Attach A* • *41-UM-AUTH 200 Attach B* • *41-UM-AUTH 200 Attach C*
CCHP's Policy and Procedure 42-040 Provider Appointment Access was outdated and did not reflect the process in place that Care Coordination, with the use of vendor CareNet, provide members with triage and screening services.	Revised Policy and Procedure 42-040 Provider Appointment Access for Triage and Screening process to reflect CCHP's use of CareNet for Nurse Advice Line to triage and screen members' calls and wait time should not exceed 30 minutes (see attachment BHI 8_10 42-040 Provider Appointment Access). CareNet began doing Nurse Advice Line (NAL) for CCHP since 3/1/2020. Included in the annual reports is wait time, which is measured in seconds and comply with the 30 minute requirement (see attachments BHI 8_10 Nurse Advice Line Access Survey Report – 2021, BHI 8_10 Nurse Advice Line Access Survey Report – 2022, BHI 8_10 Nurse Advice Line Access Survey Report – 2023, BHI 8_10 Nurse Advice Line Access Survey Report – 2024).	✓ Policy updated April 29, 2025. See document: *42-040 Provider Appointment Access* ✓ See documents: ○ *BHI 8_10 42-040 Provider Appointment Access* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2021* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2022* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2023*

		○ *BHI 8_10 Nurse Advice Line Access Survey Report - 2024*

Finding #9 [MS with PNM]: The Plan is operating at variance with its filed provider directory policies and procedures.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
Lack of consistency in identifying, documenting, and reporting potential provider directory inaccuracies, due to unclear procedures and insufficient staff training.	✓ Provide refresher training to CSRs to follow the standardized procedures established by the Provider Relations Department for identifying, documenting, and submitting provider directory inaccuracies. ✓ Create a dedicated contact reason code labeled "Provider Directory Inaccuracy" within the call/documentation system to ensure proper workflow routing to the Provider Relations Department for investigation and updates. ✓ Conduct mandatory training for all CSRs on the new procedures.	Target date of completion: 6/30/2025.

Finding #10 [MS]: The Plan is operating at a variance with its filed *Provider Appointment Access Standards* policy.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
CCHP did not provide the DMHC with Care Coordination's Nurse Advice Line reports, which demonstrate the waiting times that triage, and screening phone calls are answered. CCHP had this process in place, but the policy 42-040 Provider Appointment Access was not updated to include the current Nurse Advice Line process.	Revised Policy and Procedure 42-040 Provider Appointment Access for Triage and Screening process to reflect CCHP's use of CareNet for Nurse Advice Line to triage and screen members' calls (see attachment BHI 8_10 42-040 Provider Appointment Access). Care Coordination has Nurse Advice Line (NAL) reports that show members' triage and screening phone call wait times, dispositions, outcomes (did the member follow nurse's advice?). CareNet began doing NAL for CCHP on 3/1/2020 ((see attachments BHI 8_10 Nurse Advice Line Access Survey Report – 2021, BHI 8_10 Nurse Advice Line Access Survey Report – 2022, BHI 8_10 Nurse Advice Line Access Survey Report – 2023, BHI 8_10 Nurse Advice Line Access Survey Report – 2024).	✓ Policy was updated April 29, 2025. ✓ See documents: ○ *BHI 8_10 42-040 Provider Appointment Access* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2021* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2022* ○ *BHI 8_10 Nurse Advice Line Access Survey Report – 2023* ○ *BHI 8_10 Nurse Advice Line Access Survey Report - 2024*

IV. GRIEVANCES AND APPEALS

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Finding #11 [MS]: The Plan does not consistently identify oral expressions of dissatisfaction as grievances.

CCHP CAP:

Root Cause(s)	CAP(s)	CAP Timeframe(s)
Lack of consistency in identifying and classifying oral expressions of dissatisfaction as grievances.	✓ Conduct refresher training for all Customer Service Representatives (CSRs) on identifying, documenting, and processing oral grievances. ✓ Implement a QA review process to monitor a sample of BH calls monthly, ensuring expressions of dissatisfaction are correctly identified and logged as grievances.	Target Date of Completion: 6/30/2025.