

Plan Response to Department's Final Report of the Routine Survey

Kaiser Foundation Health Plan, Inc. ("Plan") is proud to provide care to over 9 million members in California. The Plan is committed to providing high-quality health services and is always seeking ways to constantly improve quality oversight and access to health care. The Plan respects the Department of Managed Health Care's (the "Department's") survey process and appreciates the opportunity to work with the Department in identifying areas that may be improved. The Plan has made many improvements in all areas and the Plan has provided the Department with internal audit results that reflect that Deficiencies #2.2, # 3 and #4 have been corrected. The Plan respectfully objects to the "not corrected" status on these deficiencies given the data that has been provided to show otherwise. The Plan is confident that the Department will deem this deficiency corrected at the next follow up Survey.

As authorized by Health and Safety Code section 1382(d), the Plan submits this response to be appended to the "Department's 2016 Routine Survey Final Report ("Final Report") that was provided to the Plan on June 12, 2017. The Plan takes the Department's findings seriously and appreciates the opportunity to respond and provide corrective actions as deemed appropriate.

Deficiency #1

The Department asserts that the Plan did not consistently verify the implementation of Corrective Action Plans ("CAPS") and did not consistently assess the effectiveness of CAPS.

As the Department notes, the Plan takes this finding seriously. The Final Report also notes that the Plan began corrective actions in the first and second quarter of 2017. The Plan's corrective action plan to ensure that PQI CAPs are validated and evaluated will be completed in Q4 2017. The Plan will continue to provide information and updates to the Department. The Plan is confident this finding will be deemed corrected at the next follow up Survey.

Deficiency 2:

2.1. The Department asserts that the Plan does not take effective and timely action when problems are identified for initial behavioral health appointment availability.

The Plan is committed to providing high-quality and timely services and appreciates the Department's acknowledgment of the Plan's significant improvement in meeting regulatory timeframes since the Department's 2012 Routine Survey. The Plan is proud of the care and services provided by our physicians and therapists. The Plan's existing performance metrics and quality improvement processes enable the Plan to exercise robust oversight of quality and access in a manner that few, if any other plans, can replicate.

Overseeing and managing care is a dynamic process that fluctuates daily, as changes in demand and supply occur. The Plan acknowledges that temporary access challenges have occurred at some sites. The Plan stresses that when access challenges occur it has taken, and continues to take, all measures possible to address such challenges. In the Final Report, the Department

acknowledges the many efforts, which include both short-term and long-term interventions that the Plan continues to implement in its effort to improve access.

The Plan appreciates the Department's recognition that the Plan has implemented many interventions while addressing a challenging union corporate campaign (involving behavioral health therapists) and while the entire country is dealing with a national shortage of behavioral health clinicians. As referenced in the Department's Final Report, the recent American Hospital Association ("AHA") white paper describes the national behavioral health workforce shortage as "daunting." The Plan and the community recognize the fact that the number of available providers in behavioral health is dwindling each year. Despite these challenges, the Plan continues to explore all options available.

Unfortunately, during this national shortage of behavioral health providers, temporary access challenges do occur, even when utilizing both the Plan's internal provider network and external providers in the community. The Plan is committed to continuing its current efforts, such as the hiring of an additional 850 Behavioral Health therapists statewide and 188 Behavioral Health physicians statewide between 2012 to May 2017, and continuing its efforts to look for new ways to improve performance.

2.2. During the current survey, the Plan did not have a process for regularly tracking availability and timeliness of behavioral health follow-up appointments and did not take effective and timely action when it identified problems.

The Plan understands that the Department is seeking long term, verifiable results demonstrating the Plan's regular tracking of behavioral health follow-up visits. As noted in the Final Report, the Plan asserts that it did have a process in place for regularly tracking availability and timeliness of behavioral health follow up appointments. During the onsite survey, the Plan provided the surveyors with evidence showing that Plan's audit process was implemented in both regions on January 1, 2016 and the training for these internal Plan audits took place in 2015, and that a new treatment plan template had been developed with input from its providers, requiring behavioral health clinicians to enter the return appointment frequency into an electronic system. The Plan also showed the surveyors evidence of treatment plan audits showing a 90% compliance with treatment plan indicators, statewide.

The Plan maintains that the efforts made as of the time of the onsite survey do demonstrate the Plan's successful performance with follow-up appointment timeliness. As noted in the Department's Final Report, The Plan's audit universe at the time of the onsite survey consisted of 2,964 cases, of those cases that had return intervals documented, the statewide audit results demonstrated 90% compliance with the treatment plan.

The Plan also reiterates that it had shared the treatment plan audit results with operational leaders, which resulted in the creation of a new treatment plan template. In addition, the treatment plan audit results were reviewed with the Regional Quality Vice Presidents of both regions and at the end of Q1 2017, the Behavioral Health Quality Oversight Committee, a

subcommittee of the Regional Quality Committee in Northern California and reported up to the Behavioral Health Council, a subcommittee of the Southern California Quality Committee.

The Plan is very pleased with the work to date related to treatment plan audits and maintains that its universe and sample sizes were more than adequate to demonstrate integrity in this exercise. Further, the statewide compliance rate for this work exceeded 90 percent on the treatment plan indicators. The Plan is confident that the Department will deem this deficiency corrected at the next follow up Survey.

Deficiency #3

The Plan does not immediately notify enrollees filing expedited grievances of their right to notify the Department of their grievance.

As noted by the Department in the Final Report, the Plan's policies direct staff to immediately inform members of their right to contact the Department about expedited grievances. The Plan acknowledges that upon review this did not happen in all cases. The Plan takes this finding seriously and as set forth in the Final Report, the Plan had identified this issue through its own internal auditing and began implementation of a CAP in December 2015. The Plan implemented several corrective actions at the time, including training and verbal acknowledgement scripts. Follow up internal audits have reflected high compliance levels: 97% in Q1 2016, 83% in Q2 2016, 92% in Q3 2016 and 97% in Q4 2016. The Plan is confident that the Department will deem this deficiency corrected at the next follow up Survey.

Deficiency # 4

For expedited grievance decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guideline used by the Plan and the clinical reasons for the decision.

The Plan acknowledges that an improvement opportunity exists in this matter. In fact, the Plan had identified this opportunity prior to the Department's survey by way of its internal auditing. The Plan began working on implementation of a CAP in December 2015. After implementation of training/retraining, follow up internal audits reflected high compliance levels: 67% compliance in Q1 2016, 89% compliance in Q2 2016, 90% compliance in Q3 2016 and 88% compliance in Q4 2016. The Plan is confident that the Department will deem this deficiency corrected at the next follow up Survey.

Deficiency # 5

The Plan does not consistently consider the "reasonable person" standard when evaluating the medical necessity of emergency services.

The Plan reiterates that its longstanding practice of applying the reasonable person standard, in accordance with Knox-Keene requirements, has not changed and the Plan does not deny these

claims on the basis of failure to satisfy this standard. If anything, the very low number of errors demonstrates the Plan's continuing commitment to its obligations under the Knox-Keene Act. In this respect, the Plan notes that out of approximately 500,000 emergency department claims submitted, only 12 were erroneously denied on the basis that the care was not emergent – *i.e.*, that the reasonable person standard was not satisfied. As soon as this error was discovered, the claims were paid.

The Plan welcomes the Department's clarification of its view that the obligations of emergency providers under the federal EMTALA statute may not be identical to the obligations of health care service plans to provide emergency care coverage under the Knox-Keene Act. In fact, the Plan notes that, in past years, the Department has on occasion used "prudent layperson" verbiage when describing this issue. (See DMHC Final Report of Follow-Up Non-Routine Survey 12, 2013, pg. 4 ("On September 9, 2011, the Department notified the Plan to revert to prior Evidence of Coverage standard language ('prudent layperson with an average knowledge of health and medicine would reasonably believe')"; DMHC Final Report of Non Routine Medical Survey Report, Jan. 20, 2012, pg. 3 (using both the "reasonable person standard" and "the "prudent layperson standard"); DMHC Final Report of Out of Network Non Routine Medical Survey, Apr. 28, 2006, Deficiencies # 5 and 6, pg. 10-14 (using the "prudent layperson standard").

In any event, there is limited practical effect because, as noted above, the Plan's policy is not to deny these claims on the basis that they are non-emergent. Nevertheless, the Plan is more than willing to ensure that it uses verbiage that appropriately aligns with the Knox-Keene Act and its implementing regulations. The Plan will submit to the Department appropriate material demonstrating that references to the federal "Prudent Layperson" standard changed to the "Reasonable Person" standard in relevant Plan documents. The Plan is confident this finding will be deemed corrected at the next follow up survey.

Deficiency # 6

For decisions to deny emergency services based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guidelines used, and the clinical reasons for the decision.

As explained above, the Plan's practice is to not deny such claims on the basis that the services were non-emergent. Because there are no denials, there would appear to be no corresponding need for the Plan to set forth specific clinical reasoning as to why the services were not emergent. The Plan reiterates that the twelve claims identified in Deficiency # 5, were the result of reviewers not following the Plan's policy. Even though the number of infractions were extremely low given the overall volume, the Plan nevertheless undertook individualized retraining of staff members, which was completed in January 2017. The Plan is confident this finding will be deemed corrected at the next follow up survey.