Kaiser Foundation Health Plan, Inc.'s

Corrective Action Work Plan

RE: October 11, 2023, Behavioral Health Settlement Agreement

DMHC Submission Date: August 15, 2024

TABLE OF CONTENTS

Executive Summary 3

Introduction and Leadership Commitment 5

Corrective Action Work Plans ....

Oversight (CAA 1) 7

Access (CAA 2) 14

Network and Referrals (CAA 3) 19

Grievance and Appeals (CAA 4) 23

Future Strike Contingency (CAA 5) 26

Mental Health Parity (CAA 6) 31

Member Communications (CAA 7) 34

Continuous Detail and Comprehensive Review (CAA 8) 36

Exhibit A, Governance Structure 42

Exhibit B, Accountable Party Index 43

Exhibit C, Roadmap and Timelines 47

Exhibit D, Summary of Improved Oversight 48

EXECUTIVE SUMMARY

On October 11, 2023, Kaiser Foundation Health Plan, Inc. ("the Plan") and the Department of Managed Health Care ("DMHC") reached a Settlement Agreement regarding the Plan's provision of behavioral health care services. In accordance with this Settlement Agreement, the Plan has developed, and begun implementing, a comprehensive, detailed action plan to transform the Plan's behavioral health delivery system to improve members' care experience and the Plan's operations, processes, and procedures to better assist members with accessing care. Program transformation includes, but is not limited to,

1) Enhancing the Plan's quality assurance program and its oversight of services provided by its contracted providers,

2) Streamlining and improving members' access to behavioral health care services and the Plan's network of providers, including external contracted providers,

3) Refining the Plan's grievance and appeals process to verify timely adjudication of complaints, and

4) Ensuring the Plan's coverage of behavioral health services is in compliance with behavioral health parity laws.

The Plan's transformation of its behavioral health care program is informed by an end-to-end review and analysis of how members access and traverse behavioral health care. A considered review of the members' journey and needed improvements to that process are fully explained in this Corrective Action Work Plan (CAWP). The CAWP is anchored in the following:

Oversight: The Plan is improving its Quality Assurance Program by leveraging direct access to claims, appointments, and other data, new analytical resources, and findings from field visits and/or from expanded, comprehensive audits of member charts. These changes will support more effective continuous performance reviews and enhanced oversight. The Plan also is implementing policies and procedures to inform when intervention is needed so members receive the medically necessary care they need. Through more robust oversight and accountability, the Plan will verify members' needs are met and the Plan is fulfilling its obligations under the Settlement Agreement and the law.

Access: The Plan is improving its procedures to ensure its members can access behavioral health appointments consistent with timely access standards. Policies and processes will be uniformly applied across the Plan's medical groups and external contracted providers, to ensure that: 1) initial, follow-up, and rescheduled behavioral health appointment access complies with the timely access requirements; and 2) care is consistent with each member's treatment plan, individualized behavioral health care needs, and the clinical criteria stated in the law, and 3) members are provided with timely behavioral health services that are based on individualized determinations of medical necessity. Examples of enhanced access include the implementation of e-booking, single-phone number access, and enhancing kp.org webpage navigation specific to behavioral health services.

Network & Referrals: The Plan has improved the ability of its members to access the Plan's network of providers, including external contracted providers, and improved the ability of members to access out-of-network providers for behavioral health services in instances where the Plan's network of providers cannot offer them timely care. Through a redesign of staffing and contractual arrangements, the Plan has increased its internal network by hundreds of Medical Group therapists and added more than 7,000 external contracted providers to the behavioral health network. The Plan developed and implemented a supply and demand dashboard to track detailed information on its appointment supply across its entire network, including its Medical Groups and externally contracted providers. Tracking by the Plan will confirm that Kaiser Permanente has sufficient provider capacity to meet member needs. The Plan is also reviewing and, where needed, updating its contract requirements, policies and processes to increase its visibility into externally contracted providers and to ensure effective corrective action processes across its entire network.

Grievance and Appeals: The Plan is improving its grievance and appeals policies and procedures to ensure enrollee grievances are acknowledged, adequately considered, and responded to within the timeframes required under the law. As part of this redesign, the Plan has developed a process through which all enrollee grievances regarding a delay or difficulty in obtaining a timely behavioral health appointment are routed to grievance coordinators specially trained on the laws and requirements around timely access to care. The Plan is also developing materials to increase awareness of the grievance and appeals process among network providers and members.

Mental Health Parity: The Plan has developed processes to ensure compliance with all behavioral health parity laws. This includes ensuring that members receive appropriate treatment based on individualized determinations of clinical appropriateness regardless of the type or severity of the members' behavioral health conditions.

Kaiser Permanente believes an individual's physical health, mental health, and social health are connected and essential to their total health. The Plan also believes in the power of its integrated system and the expertise of its network physicians and therapists to deliver excellent mental health care as an equal and essential part of a person's overall health care. Kaiser Permanente's focus on health outcomes, evidence-based care, and research, builds on the integrated model and guides continuous improvement activities. While the Plan has made many enhancements to its mental health care delivery system, there is still work to be done to ensure interventions and therapies are aligned with members' expectations and that members achieve the best patient outcomes.

This CAWP acknowledges the Plan's full accountability for its performance, addresses shortcomings, acknowledges work undertaken to-date to improve mental health care, and ensures that ongoing investments not only help the members of Kaiser Permanente but also build a stronger mental health foundation in the communities the Plan serves.

INTRODUCTION

Kaiser Foundation Health Plan, Inc. ("KFHP" or "the Plan") is a health care service plan with 9.4 million members in California. The Plan's members primarily receive care through the Plan's arrangements with two exclusively contracted medical groups, The Permanente Medical Group, Inc. ("TPMG") and Southern California Permanente Medical Group ("SCPMG") (collectively, "Medical Groups"), as well as with Kaiser Foundation Hospitals ("KFH"). The Plan, TPMG, SCPMG, and KFH are referred to collectively as "Kaiser Permanente." The collaborative relationship among these entities was established over 75 years ago.

On October 11, 2023, the Plan and the Department of Managed Health Care ("DMHC" or "Department") entered into a Settlement Agreement with respect to the Plan's provision of behavioral health services. In connection with the Settlement Agreement, the Plan committed to transformational change of its behavioral health services program and to fully address the deficiencies identified by the Department's investigations.

The Settlement Agreement identifies "Areas of Concern" with corresponding Corrective Action Areas ("CAA"). The Settlement Agreement stipulates that the Plan will collaborate with external consultants to develop a Corrective Action Work Plan ("CAWP") to address the concerns outlined in the Settlement Agreement including the eight enumerated Corrective Action Areas.

This Corrective Action Work Plan is supported by our leaders at the highest levels. The Plan's Chair and Chief Executive Officer, Greg A. Adams, confirmed Kaiser Permanente's commitment to transforming its behavioral health care services program in the following statement:

Greg A Adams,
Chair and Chief Executive Officer, Kaiser Permanente

"Kaiser Permanente believes an individual's physical health, mental health, and social health are connected and essential to their total health. We also believe in the power of our integrated system and the expertise of our physicians and therapists to deliver excellent mental health care as an equal and essential part of a person's overall health care.

Our agreement with the DMHC takes full accountability for our performance during the survey period including our shortcomings, acknowledges our work to improve mental health care, and ensures that our ongoing investments not only help the members of Kaiser Permanente but also build a stronger mental health foundation in the communities we serve.

We are committed to transforming the quality and outcomes for patients receiving mental health care in California. We are proud to work together with our Permanente Medical Groups and our network clinicians to deliver high-quality care to our members. We are committed to working together to meet the needs of our members and communities, and to meet the new challenges in our society around mental health."

Implementation of the CAWP is led by executives from the Plan and the Medical Groups, as reflected in the enclosed Exhibit A. Leaders from Behavioral Health, Quality, Compliance, Contracting, Member Services, and other departments are accountable for the deliverables for specific workstreams, as reflected in the Accountable Party Index enclosed as Exhibit B. In furtherance of the express obligation to continuously review whether the Medical Groups are

appropriately performing behavioral health responsibilities, the Plan has integrated this comprehensive and systemic review throughout the CAWP and included regular reporting of its findings and corrective actions.

To lead transformational change of the behavioral health care services program, the Plan has hired two Vice Presidents of Behavioral Health & Wellness—one for Northern California and one for Southern California—who are responsible for day-to-day oversight and implementation of the Plan's Corrective Action Work Plan activities and of transforming behavioral health services for members. The Plan has also hired a statewide Associate Chief Medical Officer, at the Vice President level, to oversee quality functions specific to behavioral health services. In addition, the Plan has retained an external consulting team with expertise in program development, implementation, oversight, and data assessment to further guide this work.

The Plan has completed an end-to-end review of the members' journey to further identify needed improvements to better meet member needs, and to streamline access to care. The Plan has made significant progress to expand access, improve pathways into care, and conduct a comprehensive assessment of member experience. Kaiser Permanente has a robust provider network to meet its members' needs and is continuously evaluating both the current and future needs of its members across behavioral health. This work has included a significant increase of hundreds of Medical Group therapists and more than 7,000 additional external contracted providers to the behavioral health network. Kaiser Permanente has improved member access by beginning to implement e-booking, single-phone number access, and enhancing kp.org webpage navigation specific to behavioral health services.

The Plan is bolstering processes to review and analyze data, including supply and demand data, to maintain proper levels of access to high-quality care. To fully achieve the goals set forth in this CAWP, the Plan is focused on ensuring it has access to all data needed to perform its oversight function, the tools to effectively use available data, and the necessary underpinnings to address identified gaps and drive transformational change. Kaiser Permanente has begun to introduce new tools and service offerings to meet its members' diverse, individualized needs, all through a coordinated network of internal and external providers.

Kaiser Permanente's planned transformational change represents a comprehensive shift to evolve the Plan's behavioral health program to meet the current and future needs of its members and the community. The Plan, the Medical Groups, and Kaiser Foundation Hospitals are aligned and fully committed to operating a leading mental health and addiction care system that reflects innovative and sustainable change.

CORRECTIVE ACTION AREAS

In connection with the October 11, 2023 Settlement Agreement, the Plan committed to undertaking a systemic overhaul of its behavioral health care delivery system to improve member experience, access to care, and quality oversight. The Settlement Agreement identifies eight CAAs, which correspond to specific areas of concern identified by the DMHC. The Plan retained and worked with a consulting team to develop this comprehensive CAWP that addresses the areas of concern corresponding to the eight CAAs outlined in the Settlement Agreement. The

Plan is committed to ensuring all necessary actions are implemented to successfully achieve the transformative change outlined in the Settlement Agreement.

This CAWP focuses on the key activities the Plan is undertaking in connection with each of the eight CAAs set forth in the Settlement Agreement. The CAWP follows the order of discussion in the Settlement Agreement beginning with Oversight (CAA 1), Access (CAA 2), Network and Referrals (CAA 3), Grievance and Appeals (CAA 4), Future Strike Contingency (CAA 5), Mental Health Parity (CAA 6), Member Communications (CAA 7), and Continuous Improvement and Comprehensive Review (CAA 8).

I. Corrective Action Area No. 1 – Oversight

In connection with CAA 1, addressing Oversight, the Settlement Agreement confirms the Plan's commitments as follows:

> ***The Plan shall improve its Quality Assurance Program, including continuous performance review and enhanced oversight of the Medical Groups and external contracted providers to ensure timely access, network adequacy, continuity of care, level of care, and quality of care for behavioral health services. The Plan must also implement policies and procedures for intervention whenever necessary, including, for example, if the Medical Groups are unable to ensure that behavioral health services are reasonably available to Plan enrollees. The corrective actions the Plan shall implement on this topic must include at minimum, the following:***
>
> ***A. The Plan shall create quality metrics and performance standards that are established and routinely monitored by the Plan and documented to ensure enrollees receive timely behavioral health appointments, as well as medically necessary behavioral health services, that are consistent with the standards under the Knox-Keene Act and regulations promulgated thereunder. Issues that are identified will be escalated appropriately and corrective action will be taken in a timely manner. (See Health & Saf. Code, §§ 1367.03, 1370, 1374.72, 1374.721; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.70, subd. (a)(3), 1300.70, subds. (b)(2)(G), 1300.70, subd. (b)(2)(H), 1300.74.72.***
>
> ***B. The Plan shall ensure that it has full transparency of and access to all necessary policies, practices, standards, and data, including real-time data, from the Medical Groups and from external contracted providers to conduct the Plan's oversight and review of the Medical Groups and external contracted providers, including, but not limited to, encounter data, appointment data, medical records, and claims information. (See Health & Saf. Code, § 1370; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.70, subd. (a)(3), 1300.70, subd. (b)(2)(G), 1300.70, subd. (b)(2)(H).)***
>
> ***C. The Plan shall improve its development of internal corrective action plans ("CAP"). The Plan shall develop a process to implement internal CAPs in a way that fully documents and analyzes the root cause of the issue to be***

corrected and sets forth clear corrective action interventions, including improvement benchmarks. When a CAP does not result in timely improved results, the Plan shall have a process, including associated documentation, that modifies the CAP to demonstrate enhanced analysis and intensified efforts. (See Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (d)(3).)

D. The Plan shall improve its measurement of behavioral health appointment access compliance. The Plan shall develop a measurement mechanism that identifies appointment requests where the resulting first offered appointment does not meet the timely access standards for behavioral health appointments. The Plan's measurement mechanism shall differentiate between and document all appointments where (1) an enrollee was offered an appointment within the timely access standards but chose an appointment outside the timely access standards; (2) those instances where an appointment within the timely access standards was not available or not offered to the enrollee, and the provider, or the health professional providing triage or screening services, did not note a non-detriment statement; and (3) those instances where an appointment within the timely access standards was not available or not offered to the enrollee, but the provider, or the health professional providing triage or screening services, did note a non-detriment statement. (See Health & Saf. Code, § 1367.03; Cal. Code Regs., tit. 28, §§ 1300.67.2.2, 1300.67.2.3.)

E. The Plan shall fully implement clinical policies and procedures to ensure consistent treatment, and inter-rater reliability (IRR) across the Plan, Medical Groups, and external contracted providers. The clinical policies and procedures, including criteria and guidelines, shall be consistent with the clinical review standards set forth in the Knox-Keene Act and regulations promulgated thereunder. (See Health & Saf. Code, §§ 1374.72; 1374.721; Cal. Code Regs., tit. 28, § 1300.74.72.).

The Plan is committed to strengthening and expanding its behavioral health oversight and improving its Quality Assurance Program. It is making substantial investments to meet all the commitments identified in CAA 1 and to fully remedy the deficiencies outlined in the Settlement Agreement.

Governance

The Plan has made substantial process changes and established new regional behavioral health teams to engage in continuous performance review and enhanced oversight. To lead these teams, the Plan has hired two Vice Presidents of Behavioral Health & Wellness—one for its Northern California region and one for its Southern California region. The Vice Presidents are Plan leaders, independent from the Medical Group, who are accountable for all areas of behavioral health, including access, member experience, and parity. They address and mitigate barriers, advocate for resources required for successful implementation of the CAWP and continuously oversee progress in implementation of needed changes. These two executives collectively have decades of deep behavioral health experience, clinical expertise, and transformative leadership experience. The Plan has also hired a statewide Vice President, Associate Chief Medical Officer

of Mental Health & Wellness, independent from the Medical Group, to serve as a clinical quality advisor to the Vice Presidents of Behavioral Health & Wellness for Northern and Southern California.

In addition to the regional behavioral health teams, the Plan will leverage the four regional Health Plan committees within the Plan's quality assurance program that have responsibility for monitoring activities related to behavioral health services. These regional Plan committees are the Access Committee, the Member Concerns Committee, the Behavioral Health Quality Oversight Committee, and the Regional Credentialing Committee. The Vice Presidents of Behavioral Health & Wellness are members of the parent quality committee Southern California Quality Committee (SCQC) and the BHQOCs. They also lead resolution of any issues pertaining to behavioral health in all the Committees.

The Plan is taking additional actions to strengthen the Regional Committees as discussed below. The Plan is responsible and accountable for providing behavioral health services to its members. While members receive care within Kaiser Permanente's integrated system, the Plan reserves the right to directly issue Corrective Actions if issues of non-compliance arise involving the Settlement Agreement, the Knox-Keene Act or other regulatory requirements. Consistent with this responsibility and commitment, the Plan has instituted specific escalation processes, as described below.

Under the leadership of the Plan's new behavioral health executives, the Plan has added new resources and hired more than twenty additional staff to build the new Regional Behavioral Health and Wellness teams. In addition to the team's clinical expertise in behavioral health, understanding of effective program operations, and substantial experience managing both people and projects, the teams have expertise in data integrity, reliability, analytics, and systems, and in the effective use of data for continuous monitoring and improvement. Lastly, the team has significant experience in performance improvement, in using tools and strategies to drive innovation, and in delivering effective change. The Plan is capitalizing on the expertise of the new staff members and deploying them to conduct data analysis, program oversight, project management and tracking of all actions in the CAWP.

The newly formed behavioral health teams' partner with the Committees described below to provide continuous oversight, drive effective action and issue resolution. These enhanced resources provide continuous performance review and oversight of the Medical Groups and external contracted providers to ensure timely access, network adequacy, continuity and quality of care for behavioral health. The Plan is committed to leveraging the expertise of the new Behavioral Health teams to guide the expansion and strengthened structure for oversight, prevention, and prompt resolution of issues. This CAWP next highlights four key categories of activities central to this work: A. Stronger Committees; B. Expanded Data Analytics, Field Presence, and Audits; C. Focused and Continuous Process Improvement; and D. Utilization Management.

A. Stronger Committees

The Regional Behavioral Health Quality Oversight Committees (BHQOCs) serve as the central governing body for behavioral health quality, regulatory requirements, and overall performance

improvement for the behavioral health services program. The BHQOCs will expand their scope and function to oversee a broader range of behavioral health performance metrics, program effectiveness, and corrective actions. For example, the BHQOCs will increase the depth and frequency of their monitoring of performance on quality metrics and compliance with regulatory requirements, clinical quality treatment plan audits, and out of network referrals.

The Plan is expanding the information and data visible to the other three regional committees that monitor the behavioral health services program. The Plan's goal is to ensure that all four committees have equal access to the necessary policies, practices, standards, and data, including real-time data, from the Medical Groups and from external contracted providers to fulfill their respective oversight duties. Critical analysis of charters, policies and procedures, membership, reporting, metrics, and escalation processes is underway to ensure committees have the necessary inputs, tools, and membership to conduct thorough reviews of behavioral health activities and to issue and monitor corrective actions when required. The analysis will be reviewed, and any recommended changes will be approved, by the Quality and Health Improvement Committee of the Plan's Board of Directors. The Plan will complete this analysis and implement necessary changes by the second quarter of 2025.

B. Regional Behavioral Health Teams

To support the Plan's regional behavioral health oversight activities, the Plan has hired more than twenty new staff to build its Regional Behavioral Health and Wellness teams. These new staff members have collective expertise in the following areas:

- Behavioral health clinical care
- Data analytics
- Program management and operations
- Clinical and data systems
- Continuous quality improvement
- Performance monitoring

C. Expanded Data Analytics, Field Presence, and Audits

An essential element of effective oversight and the Plan's ability to drive system change is having reliable, timely data regarding program design, implementation, and evaluation, as well as data regarding the member experience. The Plan is focused on a multi-prong effort to better understand member experience with behavioral health services and to ensure it has the necessary information to support its change initiatives.

The Plan's oversight strategy is led by the Vice Presidents for Behavioral Health and supported by the Associate Chief Medical Officer. The Plan's oversight strategy has three components: (1) improved data analytics; (2) enhanced field presence (3) expanded chart audits.

1. Data Analytics

The Plan is actively improving its data analytics capabilities to better understand how its internal and external network delivers care, its network's performance, and achieved results. It is ensuring it has the systems, necessary, timely information, and direct access to data, to continuously assess timely access, network adequacy, continuity of care, level of care, and quality of care. With this information, the Plan will better understand what members are experiencing, identify gaps, and take prompt action to better serve members. The Plan's success in these spaces is facilitated by both new resources and enhanced data sharing with its Medical Groups. It is also supported by expanded reporting from externally contracted providers.

The new analysts on the behavioral health team regularly review data to assess key areas of performance and quality. The four highlighted committees additionally analyze data focusing on access, treatment plan audits, network adequacy, credentialing, and member concerns including complaints and grievances. Where noncompliance or opportunities for improvement are identified by the behavioral health team or any committee, Kaiser Permanente works to develop corrective actions and monitors their implementation. When issues persist beyond progressive escalation, Kaiser Permanente takes additional remediation measures, up to and including termination.

To further leverage data to address access to high quality care, Kaiser Permanente developed and implemented numerous monitoring methodologies and reporting tools. The Plan is implementing and/or requiring development and implementation of additional enhancements. For example, a near-term area of focus is to develop and implement a single monitoring methodology for initial appointments that is compliant with timely access standards and used statewide for reporting when appointments are first offered, consistent with California Senate Bill 221 ("SB 221"). In addition, Kaiser Permanente is implementing a single monitoring tool to measure current access availability and to forecast future access needs. The Plan is focused on improving its visibility and oversight of network providers by analyzing data related to every point in a member's care journey to highlight opportunities to improve care delivery, address fallouts, and close any gaps in its delivery system. Efforts are also underway to improve the Plan's visibility into and oversight of externally contracted providers. For externally contracted providers, the Plan is developing reporting tools with metrics on initial and follow-up access, complaints and grievances, and quality of care. The Plan is actively working to standardize reporting of timely data regarding its provider network, need and availability of specialty providers, referral volumes, member-provider connection rates, continuity of care, and member satisfaction surveys. The Plan will be expanding its efforts to oversee treatment plans, treatment progress, time to initiation of visits, the extent to which patients referred to an external provider are not connected to care, and continuity of care processes. Findings from the Plan's data analytics work, and any necessary responsive actions, will be included within the scope of quarterly summary reports.

2. Field Presence

The Plan seeks to gain a deeper understanding of members' experiences within the behavioral health continuum, internally and externally, which includes clinics, telehealth services, and

higher levels of care. To achieve this, the Plan is prioritizing (1) focused quality visits (in-person and virtual), and (2) assessment of internal and external virtual care platforms.

Focused visits will include chart audits, monitoring of access and booking practices, and reviews of policies and procedures. The Plan will expand the number of quality visits conducted and will ensure similar reviews are conducted with the external network. The Plan will also conduct comprehensive quality visits when issues or non-compliance are identified through its data analysis, chart reviews, complaints and grievances or other oversight activities. Findings from these visits and assessments will be used by the regional behavioral health teams, and if needed, findings will be shared with the appropriate regional committees.

3. Audits

The Plan is expanding the scope and number of chart audits to support greater depth in understanding of whether members' individualized care needs are being met and that services are provided within program standards. The Plan's existing chart review process includes monthly quality monitoring of member's treatment plans. Chart reviews include the appropriateness of recommended treatment types, level of care, and follow-up care plan. In addition, auditors ensure treatment is based on individualized determinations and that recommended intervals are appropriate. Audit results are subject to continuous evaluation by plan quality staff, behavioral health leadership within Kaiser Permanente, and by regional quality committees to confirm applicable standards are met. If performance standards do not meet internal thresholds, corrective action plans are issued and monitored for performance improvement. These chart audits are used by behavioral health leadership staff and regional committees to evaluate whether care is delivered consistent with applicable clinical and regulatory standards.

Audits are conducted by the Plan's behavioral health clinical reviewers who are managed by licensed behavioral health clinicians employed by the Plan, and report to the Plan's Vice Presidents of Quality, Safety and Regulatory. Behavioral Health clinical quality reviewers receive in-depth training and participate in quarterly Inter-Rater Reliability (IRR) testing to ensure consistency and reliability of audit finding interpretation.

The Plan is expanding its audit program to include: (1) adding an additional metric to treatment plan audits to confirm a member is undergoing the course of treatment recommended by the member's treating provider; (2) increasing the volume and frequency of audits in the external provider network to better align with external referral volumes; (3) auditing out-of-network referrals to track trends and member care needs and evaluate opportunities to expand in-network offerings to meet members' evolving clinical needs; and (4) expanding its current risk assessment audit to encompass all appointments booked outside of timely access requirements, including follow-up appointments. In addition to timely and specific reporting to the appropriate oversight committees, findings from the Plan's data analytics work, and any necessary responsive actions, will be included within the scope of the Quarterly Summary Report.

D. Focused and Continuous Performance Improvement

The Plan is taking action to ensure it has appropriate processes, policies, and systems to effectively and efficiently support performance improvement. It is improving its corrective

action processes so clear and effective action is taken where areas of noncompliance and opportunities for improvement are identified. In corrective action plans, root causes and interventions are fully documented and implemented, and monitored by the appropriate quality committee. The Plan has established a progressive escalation process to support more effective and prompt action to prevent and remedy issues, bottlenecks, or deficiencies. The Plan is also expanding its efforts to support consistent, appropriate, and quality care both internally and externally.

The Plan identified areas for improvement of its corrective action processes and is making changes to effectively monitor implementation of CAP's. If compliance or remediation of deficiencies is not occurring as quickly as it should, the Plan will increase its intervention efforts through interviews, quality audits and revisions to corrective action plans. The Plan will make any necessary changes to policies, procedures or processes to address gaps or needed improvements with the internal network as part of its strengthening oversight committees or through other actions that can be accomplished within its existing contracts and annual agreements. Kaiser Permanente is reviewing, and as needed, updating contracts with external network providers to incorporate additional quality oversight requirements and to include sufficient specificity regarding consistent corrective action management processes.

The behavioral health departments and committees have enhanced accountability through progressive escalation pathways illustrated in the chart below. As concerns arise, the Vice Presidents of Behavioral Health work to resolve the issue or area of non-compliance. If they are unsuccessful, senior Vice Presidents of Care Continuum and Clinical Services are engaged. If in turn they are unable to address the issue, the Plan's Regional Presidents are engaged. Ultimately, issues can be referred to the Executive Group President for final adjudication and resolution.

*Escalation is not always linear there could be several real -time solutions if a situation needs to be resolved immediately, such as leadership escalation or situation management teams

If corrective action plans and the targeted strategies outlined above are not remedying deficiencies identified in a timely manner or if there are serious issues adversely impacting member care, the Plan, recognizing its accountability, will directly intervene. The Plan will tailor interventions to maximize their effectiveness and minimize disruption, and to the extent possible align with its integrated model of care. Interventions will vary based on the circumstances and may include the Plan directly arranging access to care for the member, as appropriate, to ensure members' needs are met and the Plan is fulfilling its obligations under the Settlement Agreement and the law.

E. Appointment Access Compliance

The Plan has developed a robust measurement mechanism to oversee its behavioral health access compliance for follow-up appointments (SB221). This mechanism identifies first-offered appointments and follow-up appointments to ensure timely access standards are met. The mechanism additionally differentiates between and documents (1) appointments where members were offered a timely appointment within the timely access standards but chose an appointment outside the timely access standards; (2) those instances where a timely appointment was not available and a provider did not document a non-detriment statement; and (3) those instances where a timely appointment was not available or not offered to the member, but the provider did note a non-detriment statement. The Plan's measurement mechanism and processes to ensure appointment access compliance are more fully discussed in Section III addressing Access (CAA 2).

F. Utilization Management

In connection with CAA 1, the Plan has undertaken efforts to review and clarify the circumstances in which the Plan engages in Utilization Management (UM) or Utilization Review (UR) of behavioral health services and ensure compliance with Health and Safety Code sections 1374.721, 1374.721, and Cal. Code Regs. Title 28 section 1300.74.721, as applicable. Specifically, the Plan is reviewing and, where needed, updating its policies and procedures concerning UM/UR, including to ensure the Plan, in conducting UM/UR in connection with all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, applies the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. The Plan will take appropriate steps to ensure consistency in UM/UR decisions in connection with all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, including through Inter-Rater Reliability ("IRR") testing of individual decisionmakers. The Plan will additionally conduct ongoing mandated training based upon updated policies and procedures regarding SB 855 and IRR to impacted staff. Findings from the Plan's review of UM/UR decisions to assess consistency and appropriateness will be included in the Quarterly Summary Report

The Plan's efforts to strengthen and expand its behavioral health oversight and improve its Quality Assurance Program require continuous and comprehensive review of the Plan's programs, and clinical offerings program, to ensure members have access to the high-quality behavioral health care services they need. Section II of the CAWP addresses the Plan's continuous and comprehensive review processes and is followed by Section III, addressing access and focusing on the Plan's improved behavioral health appointment access compliance.

II. <u>Corrective Action Area No. 2 – Access</u>

In connection with CAA 2, addressing Access, the Settlement Agreement confirms the Plan's commitments as follows:

The Plan shall improve its procedures to ensure that its enrollees can access behavioral health appointments consistent with timely access standards. The corrective actions the Plan shall implement on this topic must include at minimum, among other things, the following:

A. ***The Plan shall develop and implement an improved policy and process to effectively monitor each enrollee's appointments, treatment plan, individualized behavioral health needs, and care consistent with good professional practice, with the Plan intervening as necessary to ensure compliance. The Plan must provide a clearly defined and fully implemented policy and process to be uniformly applied across the Plan, all Medical Groups, Medical Group providers, and external contracted providers, to ensure that initial, follow-up, and rescheduled behavioral health appointment access complies with the timely access requirements, and is consistent with each enrollee's treatment plan, individualized behavioral health needs, and the clinical criteria stated under the Knox-Keene Act and regulations promulgated thereunder. The policy and process shall ensure that the Plan requires the Medical Groups and external contracted providers to fully document in the enrollees' medical records the date and time the enrollee requested behavioral health appointments, the date and time of the first available appointment that was offered to the enrollee, the date and time of the appointment the enrollee accepted, and if a statement of non-detriment or patient preference is documented in the enrollee's medical record. The policy and process shall further ensure that enrollees are provided with timely behavioral health services that are based on individualized determinations of medical necessity. (See Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subds. (a)(3), (b)(1), (b)(2)(G), (b)(2)(H).)***

B. ***The Plan shall improve, for both Medical Group providers and external contracted providers, the processes for appointment booking and documentation related to behavioral health services, including, but not limited to, booking of initial and follow-up behavioral appointments within the timely access standards under the Knox-Keene Act and regulations promulgated thereunder. (See Health & Saf. Code, § 1367.03; Cal. Code, Regs., tit. 28, §§ 1300.67.2.2, subd. (b)(2).)***

C. ***The Plan shall continuously assess whether the Medical Groups are performing their obligation to the Plan to ensure that behavioral health services are available consistent with good professional practice and timely access standards to Plan enrollees. If the Plan determines that the Medical Groups are not performing these delegated functions, the Plan must intervene and take whatever steps necessary to ensure compliance. (See Health & Saf. Code, §§ 1367.03, 1370; Cal. Code Regs., tit. 28, §§ 1300.67.2.2; 1300.70.)***

The Plan is committed to ensuring members can seamlessly access care, receive timely and consistent access to behavioral health services across its provider network and have treatment plans that are based on member's individualized behavioral health care needs. Consistent with its

commitments, the Plan has substantially expanded its provider network and instituted policies and processes to ensure it manages, maintains and as needed, refines its network capacity. As described in Section I – CAA 1– Oversight, the Plan has expanded resources and is instituting numerous changes to conduct more effective oversight of its providers. In addition, the Plan completed a comprehensive review of the member experience, described in more detail below, to inform areas of opportunity to improve access.

The Plan will implement additional actions described below so initial, follow-up, and rescheduled appointments are consistently provided in compliance with timely access requirements across its provider network. It will also implement changes to make it easier for members to access and navigate behavioral health services. Lastly, with its expanded capacity to provide more effective oversight and to promptly resolve issues, the Plan will continue to focus on providing timely and sufficient access, on meeting members' individual needs, and on ensuring consistency in how members experience access across the State where feasible. Based on its oversight of performance in this area, at a minimum, the Plan will include its findings and responsive actions in the Quarterly Summary Report, in addition to specific reporting to the appropriate Committees, and, where warranted, escalation to executive leadership.

A. Ensuring Timely Access Across the Plan's Entire Provider Network

An essential underpinning of providing timely access is having an appropriately sized provider network. The Plan recognized its provider network was insufficient to meet increasing member needs, particularly after the COVID-19 pandemic, and took action to remedy this deficiency. Over the past four years, Kaiser Permanente has substantially expanded its external contracted network. It also significantly increased its internal Medical Group staffing. In total, Kaiser Permanente expanded its network of externally contracted providers by more than 7,500 clinicians including specialists in pediatrics and adolescents, eating disorders, and trauma-informed care, and it hired hundreds of additional clinicians internally. For additional details regarding Kaiser Permanente's expanded provider network, see Section III – CAA 3– Network & Referrals.

The Plan is focused on refining and managing its provider network to maintain continued accessibility for its members. Doing so effectively and sustainably requires ongoing assessment of the demand for services against the available supply, and immediate action to address any gaps. The Plan's Southern California and Northern California regions developed a comprehensive, detailed supply and demand dashboard to regularly inform strategic network management, contracting, and staffing decisions. The Plan leverages the dashboard to ensure initial and follow-up behavioral health appointment access complies with the timely access requirements under the Knox-Keene Act.

The current dashboard includes supply of initial and follow-up appointments across the Plan's entire network—both Medical Groups and externally contracted providers. It includes detailed information on appointment supply and the percentage of appointments booked within access standards. It displays the percentage of initial appointments booked internally and externally and tracks the total capacity of the current network. In addition, the dashboard tracks internal Medical Group staffing supply, including total current therapists, total vacancies, and incoming expected hires, as well as external contracted provider network data, including the number of

current contracts and providers. The dashboard is a key component of the Plan's oversight of the medical groups' performance under Section 8 – CAA8 – Continuous Detailed Review.

Kaiser Permanente will regularly refine the supply and demand dashboard as needed. The behavioral health teams will independently analyze the underlying data to create insights for predicted demand in comparison with known supply. In addition to leveraging supply and demand data, Kaiser Permanente regularly reviews appointment access data to identify gaps and opportunities for improvement. The Plan regularly monitors, at least monthly, each medical centers' compliance with the 10-day regulatory timely access requirements for behavioral health appointments. It also monitors, on a monthly basis, documentation of non-detriment for initial access and SB221 standards. It conducts comparable analysis across externally contracted providers.

Kaiser Permanente will be strengthening and standardizing its policies and processes to ensure initial follow-up and rescheduled behavioral health appointment access is consistent with timely access, individualized behavioral health needs, and individualized determinations of medical necessity. It will also be strengthening its requirements related to documentation of when an enrollee requested care and when they received it. In addition, Kaiser Permanente will expand monitoring of Medical Groups,' to ensure clinicians have appropriate return access availability for members under their care.

To further support timely access, Kaiser Permanente created the ADAPT (Achieving Depression and Anxiety Patient-Centered Treatment) program based on the evidence-based model Collaborative Care (CoCM). The ADAPT program provides virtual, evidence-based treatment to effectively treat patients with mild to moderate depression and/or types of anxiety to remission. Treatment includes individual therapy and medication management if needed. The creation of this program has expanded Kaiser Permanente members' access to behavioral health services.

In addition to new program offerings, Kaiser Permanente is committed to addressing statewide shortages of behavioral health providers by actively supporting several workforce development initiatives, including the Kaiser Permanente Mental Health Scholars Academy (MHSA) described in detail in Section III – CAA 3 – Network & Referrals.

B. Enhanced Monitoring and Documentation of Timely Access

The Plan is fully committed to ensuring timely appointment access for its members. Meeting this goal requires continuous, comprehensive monitoring of appointment access with robust data and documentation. The Plan's current monitoring efforts include assessing timely access performance for both initial and follow-up behavioral health appointments across the Plan's entire network as described above. This work is supplemented by individual chart reviews to confirm appropriate supporting documentation is in place. The Plan is taking additional actions to strengthen these chart reviews to increase frequency, scope, and volume. As part of the expanded chart review process, the Plan's audit team will ensure that in instances where a follow-up appointment is booked outside of timely access standards, the treating clinician determined there was non-detriment to the member and noted in the chart. Further, the audit team confirms whether the chart reflects appropriate management escalation whenever a clinician is unable to offer a follow-up appointment within timely access standards. If the audit

team observes gaps in escalation or clinical documentation, the team will develop and monitor corrective action plans to support removing barriers to timely access and ensuring that bookings are clinically appropriate. The Plan is committed to arranging for out-of-network services if timely access standards cannot be met. Kaiser Permanente's model of care empowers treating providers to direct clinical care based on a member's individualized needs. The monitoring processes described above additionally serve to confirm that appointments are offered based on the treating provider's assessment of clinical need, and not based on appointment availability.

In addition to the activities described, which apply to the Plan's entire behavioral health provider network, Kaiser Permanente is focused on additional work specific to external contracted provider oversight, including enhancing reporting and data sharing. This work includes monitoring time from referral to the member being seen by the external provider to confirm timely access is being met. Its efforts in this space necessarily balance data and oversight needs with the burdens placed on external contracted providers, including smaller provider offices with less sophisticated data capabilities. Reporting for external contracted providers include referral volumes, initiation of care, average wait between referrals and treatment initiation, the extent to which members are referred to but not connected with care, and continuity of care considerations.

Anytime the Plan identifies noncompliance, performance issues, or opportunities for improvement within its network—whether Medical Group or external contracted providers– Kaiser Permanente will work with the impacted groups/providers to develop and implement all necessary corrective actions. Should actions fail to remedy the situation, Kaiser Permanente will use additional intervention, escalation processes and actions described in more detail in Section I – CAA 1 – Oversight and Section VIII—CAA 8—Continuous Improvement and Comprehensive Review. The Plan will, as appropriate, include necessary interventions and escalation processes in its Quarterly Summary Report.

C. Improved Processes for Appointment Booking

The Plan conducted a comprehensive assessment of the members' journey to care to understand pain points and identify concrete opportunities for improvement. It engaged a global consulting firm to gather feedback from current and former Plan members, conduct analyses, and support development of system improvements. Valuable insights were gathered through interviews, anonymous survey data, and analysis of member complaints, grievances, and appeals. Surveys were sent to 380,000 current and former members. More than 6,000 survey responses were received and analyzed, millions of encounters and claims data were analyzed, and dozens of in-depth interviews were conducted. The consulting firm also conducted a competitor analysis to capture current market realities and competitor offerings.

Member pain points identified included confusion on how to access care, lack of awareness of behavioral health service offerings and difficulty navigating behavioral health services (e.g., numerous touch points, multiple phone numbers, etc.).

The Plan has already begun implementing changes to streamline appointment booking and improve the member experience. These improvements include implementing a single regional phone number for ease of care and access, changes to digital experience and enhancements to

kp.org. The Plan will be implementing more changes to further improve the member experience. It will continue to improve the digital experience via enhancements to KP.org and the mobile application and through expanded direct booking with internal and external contracted providers. The Plan will complete a systemic evaluation of existing programs supporting appointment booking, including Tridiuum, Tapestry and eConsult, to identify opportunities to further streamline booking processes.

D. Improved Front Door and Access to Follow-Up Care

The Plan recognizes the need to improve front door access—meaning how members first engage with Kaiser Permanente's behavioral health entry paths—and the Plan's provision of timely follow-up care. The Plan is implementing several changes to streamline access to care, both initially and once treatment is underway. Improvements to these processes were informed by the consulting firm's work described above.

In connection with front door access, the Plan has implemented a single behavioral health phone number in its Southern California region. This toll-free number is a single point of contact allowing members to access care and schedule appointments with internal and external network providers. The Plan is in the process of implementing a similar single phone number in its Northern California region and anticipates it will be operational by early next year.

In terms of follow-up care, the Plan has taken steps to make it easier for members to schedule follow-up appointments. Current initiatives include expansion of e-booking capabilities. The Plan's goal is to explore the establishment of a convenient digital booking process for behavioral health services. The Plan is also reviewing the practice of scheduling multiple follow-up appointments in advance. Currently, multiple appointments for behavioral health members can be scheduled based on clinical need and unique patient circumstances, although this is not done commonly. The Plan is initiating a feasibility study to determine the impacts of promoting the practice of booking multiple behavioral health appointments in advance, and whether such an increase might negatively impact access to care due no-show rates or last-minute cancellations.

III. <u>Corrective Action Area No. 3 – Network and Referrals</u>

In connection with CAA 3, addressing Network and Referrals, the Settlement Agreement confirms the Plan's commitments as follows:

> ***The Plan shall improve the ability of its enrollees to access the Plan's network, including external contracted providers, for behavioral health services, and improve the ability of its enrollees to access out-of-network providers for behavioral health services in instances where the Plan's network cannot offer enrollees timely care.***
>
> ***A. The Plan shall review, monitor and participate in the process of issuing referrals to external contracted providers and out-of-network providers for behavioral health services. The Plan shall participate and oversee the process of scheduling of behavioral health appointments with external contracted providers and out-of-network providers within the timely access standards required under the Knox Keene Act and regulations promulgated***

thereunder. The Plan shall not, and must ensure that the Medical Groups do not, prohibit a referral to an external contracted provider based solely on a determination that the enrollee has a severe or chronic condition that requires care to be performed by Medical Group providers. (See Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code, Regs., tit. 28, § 1300.67.2.2.)

B. The Plan shall improve and oversee the collection of external contracted provider access data. The Plan's external contracted provider network shall be fully integrated into the Plan's behavioral health access monitoring plan, processes, systems, and reporting structures. The Plan shall ensure that enrollee appointment access when an enrollee is referred to an external network complies with timely access standards. The Plan shall ensure that the Plan has full transparency of and access to all necessary data from the external contracted providers so that the Plan can conduct its continuous, oversight, review, and intervention as necessary, including, but not limited to, encounter data, appointment data, medical records, and claims information. (See Health & Saf. Code, § 1367.03, subd. (f)(1); Cal. Code, Regs., tit. 28, § 1300.67.1, subd. (c).)

C. The Plan shall develop a process for identifying members who attempted, but were unable to, obtain timely and clinically appropriate behavioral health services in-network and, as a result self-referred to an out-of-network provider. The Plan will develop a process for evaluating enrollee out-of-network claims for reimbursement. The terms of such reimbursement will be subject to agreement between the Plan and the Department. The Plan shall present the process required by this paragraph to the Department no later than the due date for the first Quarterly Report, as provided in Paragraph 109 above.

The Plan is implementing numerous changes and making substantial investments to strengthen our behavioral health network and referral process.

A. Improved Network Access and Referrals

The Plan's efforts to improve network access and referral processes include (1) managing and refining its provider network, (2) streamlining the process for member referrals to external providers—whether contracted or non-contracted, (3) leveraging data to comprehensively monitor access, with a focus on external providers, and (4) improving provider credentialing and contracting processes. The Plan is fully committed to ensuring that anytime it is unable to offer a timely and clinically appropriate appointment to a member based on clinical determination, an appointment will be arranged for the member with an out-of-network provider who can meet the member's clinical needs in a timely fashion.

1. <u>Expanded Provider Network</u>

The Plan has substantially increased its network of behavioral health providers in the past two years. For example, the Plan has significantly expanded its external provider network to increase

capacity and ensure diverse expertise to treat Plan members. These expansion efforts include large provider groups such as Grow Therapy and Little Otter in Northern California, which have dedicated child and couples' therapists, and Rula in Southern California which offers individual therapy and dedicated child therapists. The Plan has added smaller groups across the state with specialty offerings including eating disorder treatment, programs specializing in obsessive compulsive disorder, and trauma-informed care. Kaiser Permanente also added over 400 behavioral health clinicians to its internal network between April 2022 and April 2024.

Although its provider network has grown significantly, the Plan recognizes the need to refine and, as needed, expand to ensure timely access to behavioral health services. The Plan will specifically consider areas and requirements that have been barriers for smaller groups and individual providers to contract with Kaiser Permanente. Additional work to ensure members have access to clinically appropriate care is described in Section II addressing CAA 2 - Access and Section VI addressing CAA 6 - Parity.

In light of behavioral health provider shortages across the nation, including in California, and to further support its network, the Plan is working to expand the pipeline of qualified, experienced, and diverse mental health professionals in California. The Kaiser Permanente Mental Health Scholars Academy (MHSA) provides tuition assistance to Kaiser Permanente employees interested in pursuing a career in behavioral health. Program participants have 75% of their tuition sponsored by Kaiser Permanente. There are currently 219 Kaiser Permanente employees enrolled in the program working towards obtaining their mental health master's or doctoral degree. The MHSA is committed to increasing diversity and representation in the mental health workforce. Of the student cohorts in the program between 2020-2023, 31% were Hispanic/Latinx, 21% were White, 18% were Black/African American, 16% were Asian, and 7% were Biracial. In addition, 40% of the candidates have been bilingual, with 93 candidates being Spanish speaking and with the group collectively being fluent in over 30 languages. This initiative is just one of the ways the Plan is focused on efforts to ensure its behavioral health provider network better mirrors the diversity of its members.

2. <u>Referrals to External Providers</u>

The Plan is improving processes to review, monitor, and oversee referrals to external contracted and out-of-network behavioral health providers. Specifically, the Plan is evaluating referral processes, updating member and provider-facing communications, and taking steps to streamline workflows to meet timely access standards and other regulatory requirements. Kaiser Permanente will improve the process for initiating and managing letters of agreement with out-of-network providers/facilities and facilitate a smooth transition of care to an out-of-network provider/facilities, including overseeing execution of agreements and/or contracts when applicable. Planned improvements include tracking monthly volumes of Letters of Agreement (LOA), to which providers/facilities, and the reason for referral.

The Plan will ensure that decisions around whether to refer a member to an external provider are not based solely on determinations around acuity. This work includes confirming the Medical Groups do not prohibit or otherwise limit referrals to external contracted providers based on a decision that care for severe or chronic conditions should be provided specifically by the Medical

Groups. The Plan will monitor, at least on a monthly basis, referrals to the external network through auditing, data analysis, and chart reviews.

The Plan will be monitoring out-of-network referrals and leveraging data to confirm members are offered appointments within timely access standards, including SB 221 and SB 855 requirements. The Plan will also monitor trends of out-of-network referrals to identify opportunities to improve its network to better meet members' dynamic clinical needs.

3. Supply and Demand Dashboard

As discussed in Section II – CAA 2 – Access, the Plan recognizes that it is critical not just to have a broad network, but also to ensure that the network is available and accessible to its members. Effective oversight in this area is contingent upon access to timely and accurate data, including timely access, appointment data, referrals, medical records, and claims from both its Medical Groups and external contracted providers.

Leveraging network data, the Plan has developed a Supply and Demand Dashboard to track detailed information on its appointment supply across its entire network, including by Medical Groups and externally contracted providers. The Plan also tracks demand for those services, so the Plan can ensure that it has sufficient provider capacity to meet member needs. Specifically, the Supply and Demand Dashboard described in Section II – CAA 2 – Access will support network management and the Plan's oversight of booked volumes for all types of mental health care. The Plan will expand existing efforts to also assess demand for in-person and virtual behavioral health services against its network capacity at least on a quarterly basis.

The Plan's data analysts will independently review supply and demand data, identify trends, and create reports, at least monthly, regarding the Plan's behavioral health provider network. The analysts will consider a wide range of inputs when conducting this work including complaints and grievance data, findings from chart reviews and audits, access reports, and member satisfaction surveys. These analytics and reports will include indicators for further action when gaps or opportunities for improvement are identified. The regional health plan behavioral health teams will review the data, analytics, and reports and regularly take action to address identified gaps or issues, to meet members' access needs. The Supply and Demand Dashboard and associated reports will be shared and discussed with the BHQOC, Access Committee, or other regional committees.

Kaiser Permanente is also monitoring and updating its external provider network roster to identify active contracted individual providers, groups, and facilities, including credentialing status. Providers not actively accepting new members, but who are listed in our provider directory, will be monitored and assessed to determine any necessary actions. Any concerns or gaps identified through Plan monitoring will be addressed by the behavioral health teams and shared with BHQOC.

4. External Provider Credentialing and Contracting

To further improve the member experience and the ability of its members to access the Plan's behavioral health network, including external contracted providers, Kaiser Permanente is streamlining its external provider credentialing and contracting processes. The Plan is critically

evaluating current provider contracting and credentialing processes and procedures to identify barriers and opportunities for optimization to onboard high-quality providers. The Plan is improving its recredentialing processes, which currently are every three years, to strengthen oversight, support high-quality care and increase accountability. In connection with contracting specifically, the Kaiser Permanente will assess whether contract terms need to be updated to facilitate additional data transparency and oversight, including relating to access and quality.

The Plan is considering strategies to better incorporate its external behavioral health provider network into its integrated system of care to better manage the patient's overall health. Kaiser Permanente's integrated model is an evidence-based healthcare system that focuses on patient outcomes and fosters collaboration among physicians, specialists, and other medical professionals. It is health care that emphasizes quality of care, provider performance, and patient experience. Consistent with its goal of more integrated services, evidence-based, patient focused care, the Plan is exploring implementing a value-based system with the external provider network. The Plan's assessment of necessary improvements in this area, and related actions, as appropriate will be included in the Quarterly Summary Report.

B. Claims Reimbursement Process

The Plan is developing a process for evaluating enrollee out-of-network claims for reimbursement and submitted a proposal to DMHC for feedback. The Plan expects to meet the deadline set forth in the Settlement Agreement by submitting the final process to the DMHC no later than the due date for the first Quarterly Report, as provided in Paragraph 109 of the Settlement Agreement. The reimbursement process will be implemented once it receives final approval by the DMHC.

IV. Corrective Action Area No. 4 – Grievances and Appeals

In connection with CAA 4, addressing Grievances and Appeals, the Settlement Agreement confirms the Plan's commitments as follows:

The Plan shall improve its grievance and appeals policies and procedures.

A. The Plan shall improve the Grievance and Appeals process by which enrollee grievances are acknowledged, adequately considered, and responded to within the timeframes required under the Knox-Keene Act and regulations promulgated thereunder. The Plan shall review its practice of referring appointment requests for which a timely appointment cannot be booked through the Grievance and Appeals review process, to ensure that this practice results in enrollees receiving appointments consistent with timely access standards separate from the time that it takes grievances to be resolved. The Plan's review shall develop processes to promptly address any enrollee grievance based, in part, on a complaint that the enrollee cannot schedule a timely behavioral health appointment. The Plan must implement a consistent procedure to ensure that all enrollees who are not offered timely appointments are reviewed for risk and their behavioral health needs are met.

(See Health & Saf. Code, §§ 1367.03, 1368, 1368.01; Cal. Code, Regs., tit. 28, §§ 1300.67.2.2, subd. (b)(2), 1300.68.).

B. The Plan shall develop a process through which all enrollee grievances regarding a delay or difficulty in obtaining a timely behavioral health appointment are routed to grievance coordinators specially trained in Department-regulated products and Knox-Keene Act and regulations relating to timely access. Although this group of grievance coordinators may primarily focus on Department-regulated products, the group of grievance coordinators may answer calls about health care products licensed in other states, should the Plan choose to have them answer such calls. (See Health & Saf. Code, §§ 1367.03, 1368.)

To meet each of these commitments, the Plan describes below improved processes designed to promptly address any enrollee grievance based, in whole or in part, on a complaint that the enrollee cannot schedule a timely behavioral health appointment, and to review and address all instances when a member is not offered timely appointments so that behavioral health needs are met. Most of the improved processes have been implemented. The Plan's goal is to meet members' needs each and every time and eradicate any access challenges for our members.

A. Identifying and Escalating Timely Access Challenges

The Plan has developed and implemented a process to identify and fast track resolution of any grievances related to access challenges faced by members. Any member grievances that suggest access challenges, such as timely access to appointments, scheduling concerns, the cadence of follow-up care, and transitions between levels of care, are flagged by specially trained grievance coordinators and escalated to local clinical department staff to assist member needs. Grievance coordinators work with behavioral health providers and clinical department staff to resolve access challenges within timely access requirements. The Plan is instituting a consistent procedure to ensure that all members who file a grievance regarding timely access are reviewed by a clinician for risk assessment and steps are taken to meet each member's behavioral health needs.

The Plan has taken material steps to accelerate resolution of behavioral health concerns. Those efforts include three significant activities: standing up a toll-free mental health escalation phone number with specialized training on resolving access challenges, training designated grievance coordinators, and instituting a statewide decision-making committee. Collectively, these changes which have already been implemented, coupled with operational improvements, have resulted in a decrease in member grievances around access. Each is addressed in turn.

B. Behavioral Health Escalation Line

The Plan launched a toll-free behavioral health customer service line to specifically address access issues, and any other concerns members may have regarding behavioral health care. This dedicated behavioral health member services line is available from 8 a.m. to 5 p.m., Monday through Friday, excluding holidays.

The resolution specialists who staff the escalation line and the call center agents who staff the general member service lines are trained to address, and in many instances can successfully resolve, members' appointment needs and concerns during the same phone call. If a resolution specialist or call center agent is unable to resolve a member's concerns, a grievance is filed on behalf of the member.

Grievances concerning behavioral health are routed to a specialized grievance team for handling. For concerns around access, the grievance team engages designated clinical liaisons who separately work to resolve access challenges within timely access standards. In those instances, the grievance is worked in parallel by the grievance team within the regulatory timeframes applicable to grievances.

Escalation line quality metrics including volume, types of concerns, escalated calls and resolution are reported to the Behavioral Health Quality Oversight Committee.

C. Grievance Coordinators

The Plan has developed a process through which all member grievances regarding delays or difficulties in obtaining timely behavioral health appointments are routed to grievance coordinators specially trained in behavioral health timely access requirements. All grievance coordinators receive targeted, mandatory training on pathways for escalation within the Plan and care delivery system, and on how to engage on-call behavioral health clinicians for clinical support. The Plan is putting additional processes in place to swiftly identify, address, and resolve behavioral health timely access concerns. Grievance coordinators are additionally trained to document timely access concerns and risk factors and to escalate appropriately.

D. Statewide Behavioral Health Decision Making Committee

In September 2022, the Plan launched a statewide committee focused exclusively on resolving non-expedited behavioral health grievances for commercial Plan members. Current committee members include clinical members, grievance and appeals experts, and legal and regulatory advisors with specific expertise regarding Knox-Keene Act statutory and regulatory requirements, including timely access, mental health parity, SB 855, and continuity of care, among others.

The committee works to ensure the appropriate criteria developed by the nonprofit professional association for the relevant clinical specialty—as mandated by SB 855—are applied consistently across all behavioral health grievances and appeals, and all regulatory requirements are met. Grievance resolutions are determined through the consideration of clinical and regulatory components while relying upon criteria-based resources prescribed by SB 855. Consistent application of the criteria is achieved through the committee's structure as a consensus-based committee. No one member has the power to decide the outcome of any grievance. Rather, each grievance is discussed in detail among committee members, with appropriate subject matter expert input as applicable, and decisions, including scoring, require consensus among all clinical members. Discussion continues until consensus is reached.

The committee's work in evaluating behavioral health grievances, statewide, supports the Plan's efforts to deliver transformational change and industry-leading services to its members. This

statewide committee enhances the Plan's real-time line of sight into its behavioral health members' experiences including internal care and care delivered by external providers. The inclusion of key operational leaders and care delivery subject matter experts on the committee facilitates real time information sharing regarding challenges, opportunities and strategies for improvement with regional leaders and care delivery teams. The Plan's behavioral health leaders are invited to, and participate in the statewide committee, watch for trends, and incorporate insights into care delivery and access improvements.

The committee's statewide structure enhances the Plan's ability to see patterns within and across medical centers and provide real-time feedback to our operational and care delivery system leaders, to problem-solve in real-time with key operational leaders and care delivery subject matter experts, and to quickly institute process improvements to address member pain points. The committee's work has had a significant impact: since the inception of this committee in September 2022, there has been marked reduction in volume of DMHC Independent Medical Reviews (IMRs) and IMR turnovers.

E. Member and Provider Education

The Plan is launching a number of member and provider-facing education initiatives to increase awareness regarding how best to bring concerns to the Plan's attention for appropriate redress. Specifically, the Plan is creating educational materials and toolkits on how members can get questions answered, and how to access and navigate the member grievance process. These materials will be regularly distributed through multiple media avenues and filed with the Department as required.

The Plan is also developing a robust set of materials geared towards provider education. These will provide information to the Plan's network of providers regarding regulatory requirements, with a particular focus on the criticality of avoiding coverage discussions with members. The materials will include necessary resources and a toolkit to direct members to the Plan for accurate information regarding coverage. The Plan will also inform network providers regarding the member grievance process and how members can access this process. The Plan will work closely with Medical Groups to develop materials and to implement provider education efforts to ensure the Plan is effectively and regularly reaching network providers.

Finally, the Plan is clarifying pathways for network providers—both internal and external—to escalate concerns directly to the Plan for appropriate action. The goal of this work is to continue to encourage open dialogue between the Plan and its network providers.

V. Corrective Action Area No. 5 – Strike Contingency Plan

In connection with CAA 5, addressing Strike Contingency Plan, the Settlement Agreement confirms the Plan's commitments as follows:

> ***The Plan shall develop a comprehensive contingency plan to be implemented in the event of future labor work stoppages that may result in cancellation of enrollee behavioral health appointments. The contingency plan shall include uniform processes for documentation of enrollee notification of appointment cancellation, and clinical review for prompt rescheduling consistent with***

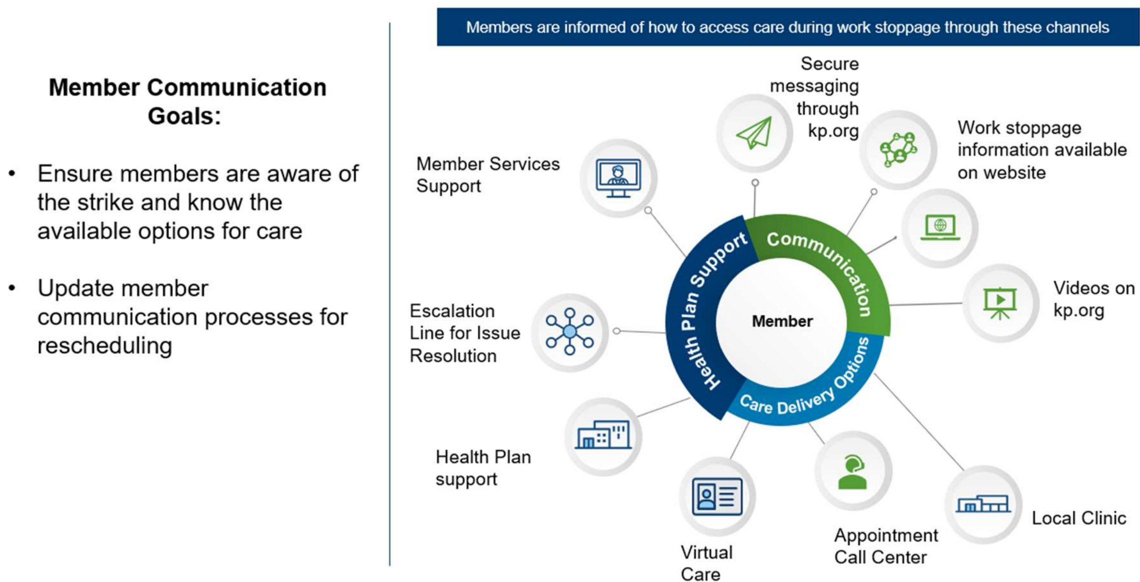
enrollees' individual treatment needs. The contingency plan shall also create a uniform reporting structure for Plan oversight of appointment cancellations and/or rescheduling. (Health & Saf. Code, § 1367.03, subd. (a)(3).)

Kaiser Permanente is committed to bargain in good faith as required under law. As required under the Settlement Agreement and consistent with its obligation to members, the Plan must have contingency plans for disruption of services. To that end, Kaiser Permanente has developed a robust, comprehensive strike contingency plan that draws on lessons learned from prior work stoppages, including the 2022 NUHW work stoppage in Northern California. The goal of the contingency plan is to minimize member disruption and maintain appropriate quality oversight. The Plan has worked since the most recent work stoppage to develop a more effective internal and external communication strategy and an enhanced regional situation management structure process to facilitate Plan and Medical Group alignment and coordination.

The strike contingency plan focuses on three key objectives outlined in the Settlement Agreement: 1) communication around work stoppages including uniform processes for documentation of enrollee notification of appointment cancellation, 2) prompt appointment rescheduling consistent with members' individual treatment needs, and 3) uniform reporting structure for Plan oversight of appointment cancellations and/or rescheduling.

A. Communication

The Plan and Medical Groups are committed to minimizing interruption in care for our members in the event of a work stoppage. A key initial step is to promptly and clearly communicate with our members regarding the potential impact of a strike. The Plan will engage in a multi-pronged communication campaign to inform members about strike activities when notification is received and remind them how to continue to access care. In the event members have concerns, the communication strategy also will instruct members how to escalate concerns including how to file a member grievance. The multiple channels of member communications are depicted in the following graphic:



Member concerns will be closely monitored during a strike through uniform documentation processes. The Plan will obtain access updates and coordinate with the Medical Groups to resolve member issues in real-time. Kaiser Permanente will also partner with the Plan's member services department to utilize updated scripting and frequently asked questions to inform members of processes, execute specialized grievance tracks for member access concerns, triage member issues and ensure appropriate escalation, and facilitate timely reporting to the Plan and Medical Groups on escalated issues. Finally, in the event a strike notice is received, the Plan will promptly inform the Department via filing, and include specifics regarding the Plan's preparation to care for its members during a potential work stoppage.

B. Clinical Review and Staffing Readiness

Kaiser Permanente is committed to ensuring members' clinical needs are assessed and addressed during a work stoppage. The unfortunate reality of a work stoppage is that many members will not be able to see their assigned clinician if they choose not to report to work. Accordingly, and to mitigate member disruption, Kaiser Permanente will focus on prioritizing urgent needs and offering timely initial and follow-up appointments. When appointments need to be cancelled or rescheduled, staff will outreach to members, provide information regarding the cancelled or rescheduled appointment, and offer a new appointment with an alternative provider. Alternative appointment timing will be informed by the member's treating provider's clinical assessment as reflected in the member's medical record. Where the treating provider did not document a return interval, an appointment with a clinician will be offered within a clinically indicated timeframe. If a member expresses any urgent needs, the member will be warm-transferred to an on-duty clinician or scheduled for an urgent appointment.

If a member elects to stay with their treating provider and declines the appointment offered, this will be documented in Health Connect and the member will be contacted by a behavioral health

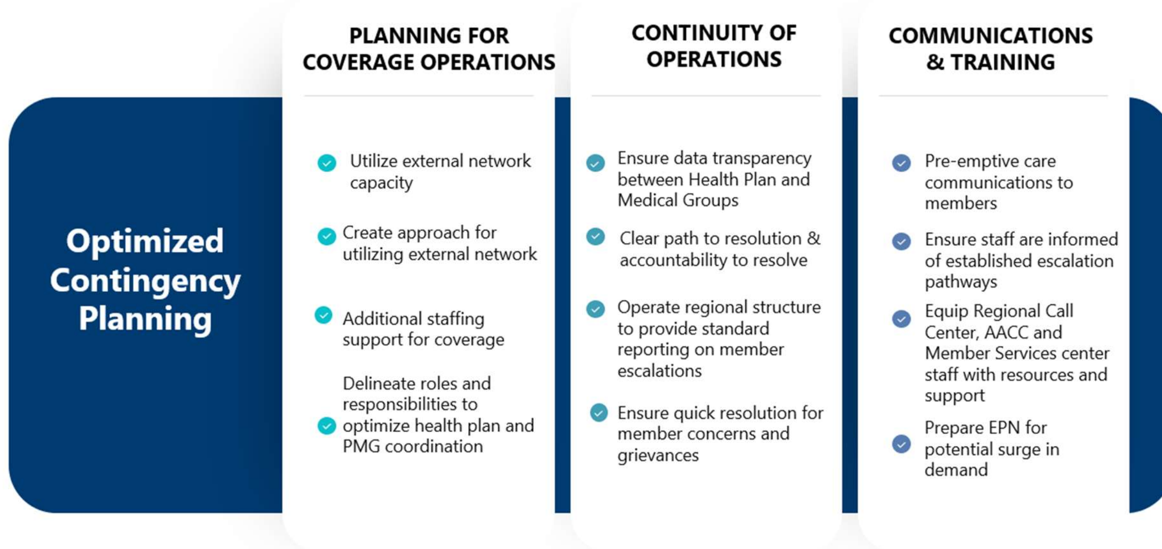
clinician for a risk assessment every 30 days. Any members choosing to wait for their treating provider will be placed on the provider list in Health Connect for tracking purposes. Members will also be informed of how to reconnect to services at any time. For any urgent appointments needing to be cancelled, the member will be offered an appointment within the urgent timeframe.

In the event of a work stoppage, Kaiser Permanente is prepared to (1) deploy available licensed clinical staff region-wide (for both in-person and virtual appointments), (2) onboarding a contingent workforce of clinical providers, and (3) leveraging the external provider network to offer additional capacity.

In addition to staffing and capacity readiness, Kaiser Permanente will provide work-stoppage related guidance to all call center personnel, including those staffing member services, clinical staff supporting the behavioral health escalation line, and clerical staff within outpatient clinics.

Kaiser Permanente will also enhance training and provide resources and support for staff who manage the appointment processes to ensure compliance with canceling and rescheduling appointments. This will include standardized scripting region-wide to inform members of the strike. Further, clerical staff will be given a daily list of on-duty providers who may assist with crisis patients and a list of readily available administrators in their clinic to escalate member concerns to.

Staff readiness efforts ensure that available clinical staff can cross-cover for the local medical centers where appropriate, and that member services, call centers, appointment scheduling, escalation staff, and contingent workers have been trained. This includes having scripting to answer questions raised, and the ability to resolve concerns expeditiously. Kaiser Permanente activities in these spaces are depicted in the following graphic:



C. Uniform Reporting Structure for Plan Oversight of Appointment Cancellations and/or Rescheduling

In the event of a work stoppage, the Plan will access and obtain real-time data

that is critical to monitoring timely access, tracking member issues, and coordinating to minimize strike disruptions as much as possible. A uniform reporting structure and documentation standards will be developed by the Plan to audit and track appointments that may be cancelled or rescheduled due to a work stoppage. This structure and standards allow the Plan, including its dedicated audit team, to continuously monitor data regarding cancelled and rescheduled appointments. The data and quality review will additionally permit the Plan to identify members (1) who are at risk, and (2) who have not been scheduled with a timely follow-up appointment, taking into account clinical needs and regulatory requirements (*e.g.*, SB 221). Kaiser Permanente's top priority will be to reschedule members in a timely and clinically appropriate manner. In the event that a member is not able to be rescheduled in a timely manner, a behavioral health clinician will attempt to contact member to complete a risk assessment.

D. Regional Incident Management Structure

In the event of a strike, the Plan, in partnership with the Medical Groups, has developed a regional structure for situational awareness, coordination, oversight, escalation, and to facilitate rapid issue resolution. This structure begins operating, as a contingency for preparedness purposes, well before any potential work stoppage. It facilitates alignment and coordination between care delivery operations, behavioral health and wellness oversight teams, and other Plan support teams such as member services, communications, and grievances and appeals. The enhanced regional structure provides greater visibility and coordination for reporting and escalations to help ensure that both Medical Groups and the Plan are working together to provide timely access and escalate concerns.

The visual below provides detail of how the regional incident management structure will support all areas of anticipated member needs during a work stoppage.

Ensure the uniform structure for situational awareness, coordination, oversight & rapid resolution

Structure:
- Refine regional structure for work stoppage
- Partner in remediation and reporting between Medical Group and Health Plan
- Build statewide alignment on incident management structure and escalation processes

Health Plan Oversight:
- Monitor member concerns to obtain access and coordinate with medical groups to resolve member issues in real-time
- Obtain timely data updates (i.e. CGAs, cancelled appointments, member escalation) via an oversight dashboard
- Oversee issue resolution & cancellations concerns
- Conduct audit of cancelled appointments to ensure members are rescheduled timely
- Focused review of member concerns and grievances post-strike

Care Delivery Operations:
- Ensure adequate access for capacity (*e.g.*, before, during & after strike)
- Ensure plan for staffing coverage and support for high- risk groups in each clinic
- Daily inventory of clinical staff and deployment of contingent staff
- Coordinate with external network
- Identify members who are impacted in each clinic for rescheduling.
- Update member communications as needed for rescheduling and cancellations

Health Plan Support:
(Member Services and Grievances)
- Utilize updated scripting and FAQs to inform members of processes and potential office closures
- Specialized grievance tracks for member access concerns
- Triage member issues and ensure appropriate escalation.
- Daily report to health plan and medical groups on escalated issues

VI. Corrective Action Area No. 6 – Mental Health Parity

In connection with CAA 6, addressing Mental Health Parity, the Settlement Agreement confirms the Plan's commitments as follows:

> ***The Plan shall develop processes to ensure that the Plan is in compliance with all behavioral health parity laws. This shall include, but is not limited to, the Plan ensuring that enrollees receive appropriate treatment based on individualized determinations of clinical appropriateness, and regardless of the type or severity of the enrollees' behavioral health conditions. The Plan shall ensure that enrollees are not directed to behavioral health group therapy, classes, smartphone applications, or "one-size-fits-all" therapy alternatives without an individualized determination that such therapy, classes, applications, or alternatives are clinically appropriate for the enrollee's individual condition. The Plan shall ensure that enrollees do not face barriers to scheduling behavioral health appointments that do not exist for non-behavioral health appointments. (Health & Saf. Code, § 1374.72, subd. (a).)***

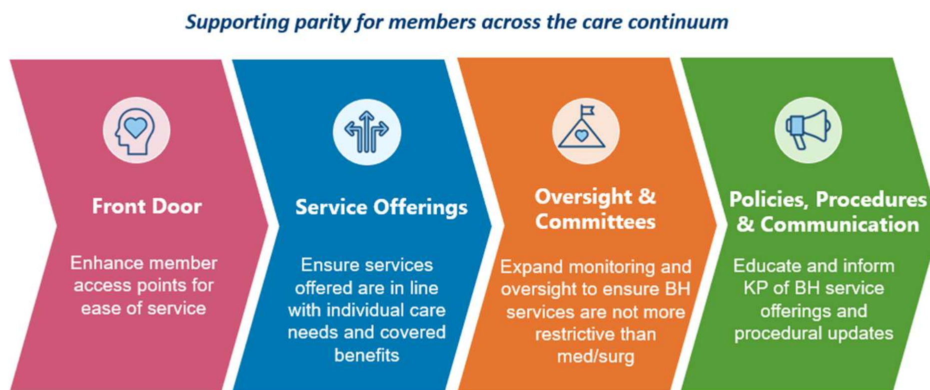
To meet these commitments, the Plan has developed and is implementing new and improved processes to ensure compliance with all behavioral health parity laws, including California State laws and the federal Mental Health Parity and Addiction Equity Act ("MHPAEA"). As discussed throughout the CAWP, the Plan is making changes to support a high-quality, coordinated, and easy-to-access behavioral health care member experience, comparable to the medical/surgical member experience. The many efforts to streamline access to behavioral health services highlighted throughout the CAWP, include enhanced access points for ease of service. These steps are not directly implicated under state or federal parity law requirements but are included

because they relate to other important sections of this CAWP and to Kaiser Permanente's commitment to a transformative behavioral health program for all members.

The Plan's multi-pronged efforts focus on the following four areas: (1) front door, (2) service offerings, (3) oversight and committees, and (4) policies, procedures, and communication. The primary work in these areas is summarized at a high level in the following graphic:

Supporting Parity

The Plan is committed to continuously evaluating and when necessary, improving processes to ensure parity for behavioral health services.



A. Front Door

The Plan is prioritizing improvements to our members' "front door" experience. The Plan recognizes a member's initial engagement with behavioral health support is a critical component of the care journey. The Plan's primary focus in this space is to streamline and enhance access to behavioral health services. Two examples of this work include leveraging a single, centralized regional phone number to initiate care and expanding digital appointment booking options. More details regarding the Plan's work to improve access are addressed in Section II.B, - CAA 2.

B. Service Offerings

The Plan is committed to meeting the individual and diverse behavioral health needs of its members by evaluating and enhancing service offerings so that members get the right care at the right time in the right place. The Plan monitors the appropriateness of service offerings based on the individual needs of the Plan's members. Oversight in this area includes, but is not limited to, monitoring trends and utilization concerning modalities of care and referrals, chart reviews of member treatment plans, and removing barriers to care.

The Plan evaluates service offerings at the individual member level to confirm alignment with unique member needs. The Plan also takes steps to monitor care decisions by providers through chart review of member treatment plans. These two activities help the Plan's regional behavioral health teams and its regional quality committees monitor service level trends and specific service utilization to forecast member needs and inform network refinement. In addition, the Plan's regional teams will conduct more frequent reviews of services that members are receiving (*e.g.*,

individual therapy, group therapy, and participation in Intensive Outpatient Programs) to identify trends that may impact behavioral health parity issues and take action as appropriate. When conducting audits as described in Section I - CAA 1, the Plan's regional teams will also evaluate whether there is appropriate and convenient member access to external contracted providers, confirm that referral limitations do not exist in any of the local Medical Center areas, and confirm members do not experience barriers when referred to external contracted providers. In instances where concerns are raised about external treatment limitations, Kaiser Permanente will investigate the specific external provider(s) and educate them that treatment limitations should not exist. The Plan is committed to educating its entire provider network that behavioral health treatment shall be based on member's clinical needs. The Plan will take steps to confirm there are no restrictions on referrals, including referrals to out-of-network providers when in-network timely access is not available.

At the organizational level, continuous monitoring of recommended treatment modalities (*e.g.*, individual therapy, group therapy, etc.) will inform the Plan of potential gaps in available services or trends toward certain treatment modalities. Out-of-network referrals will also be reviewed to identify opportunities for expanding the Plan's network to meet members' dynamic needs. Monitoring will be conducted by regional behavioral health teams as well as health plan committees. The Plan will report potential gaps to its Behavioral Health Quality Oversight Committees ("BHQOC") and appropriate leadership for input on root cause analysis, and support implementing necessary corrective actions. The Plan's service offerings will be regularly reviewed and updated, as described more fully in Section VIII - CAA 8.

Finally, in an effort to remove barriers to care, the Plan is reviewing the practice of scheduling multiple follow-up appointments in advance. Currently, multiple appointments for behavioral health members can be scheduled based on clinical need and unique patient circumstances, although this is not done commonly. The Plan is initiating a feasibility study to determine the impacts of promoting the practice of booking multiple appointments for behavioral health. The Plan wants to ensure that multiple visit scheduling does not lead to higher no-show rates which, in turn, would impede access for others.

C. Oversight & Committees

The Plan is strengthening its oversight committees, expanding its data analytics capacity, increasing access to data, establishing new escalation processes to drive results, focusing on SB 855 compliance, and leveraging its new behavioral health teams. The Plan is also taking the following specific actions to comply with parity laws and regulations.

1. <u>Strengthening Nonquantitative Treatment Limitation (NQTLs) Comparative Analysis</u>

The Plan has strengthened the NQTL comparative analysis process to enhance rigor and consistency across dedicated regional teams of multidisciplinary stakeholders. The Plan has implemented an improved process to ensure that the data relied upon for NQTL comparative analyses are consistently identified, documented, and collected.

In terms of the technical aspects of this work, the source and interpretation of the data is dependent on the respective NQTL and benefit classifications. The dedicated NQTL teams work directly with the subject matter experts to translate the business process into applicable data requirements which includes a systematic review of the benefit classifications to illustrate the effect of the NQTL's application in practice. As a part of the analysis, NQTL findings and lessons learned for performance improvement will be escalated as appropriate and regularly reported to BHQOC.

2. Increasing BHQOC Focus on Compliance with Parity

The Plan is committed to taking action based on parity findings from NQTL comparative analyses through chart audits, and all other sources. The regional BHQOCs are responsible for overseeing parity. Those committees will increase their focus on compliance with parity laws and regulations through multiple activities including reviewing and identifying trends with any access bottlenecks or unusual referral patterns, monitoring treatment modalities, and closely examining complaints and grievances relating to service offerings, barriers to care, and covered benefits. Additionally, both the BHQOC and regional behavioral health teams will conduct regular reviews of out-of-network referrals to build-out the Plan's network to better meet evolving member needs. The Plan will include any pertinent findings and responsive actions from this focused review in the Quarterly Summary Report.

D. Policies, Procedures and Communication

The Plan is conducting a comprehensive evaluation, and where needed, updating its policies and procedures to ensure they comply with parity laws and regulations. This includes, as described more fully in Section I addressing CAA - 1, the Plan's efforts to review and clarify the circumstances in which it engages in Utilization Management or Utilization Review, and confirm it is consistently applying the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty as mandated in SB 855.

The Plan is also expanding efforts to boost provider awareness of parity laws and regulations. The Plan is developing toolkits and educational materials to ensure providers are well-informed of mental health parity laws and regulations and have access to nonprofit clinical criteria to support treatment planning. In addition, the Plan will offer, at no cost, training to its providers on the nonprofit clinical criteria.

As described in detail in Section VII - CAA 7, the Plan is reviewing all member-facing information and communications to confirm there is parity in how the Plan explains behavioral health services in comparison to medical services. This review will include analysis of electronic and paper information and communications to support compliance with behavioral health parity requirements. The Plan will take necessary actions to address any gaps.

VII. Corrective Action Area No. 7 – Member Communications and Advertising

In connection with CAA 7, addressing Member Communications and Advertising, the Settlement Agreement confirms the Plan's commitments as follows:

The Plan shall conduct a comprehensive review of all Plan communications and representations to enrollees, including any related policies, procedures, and training materials, regarding behavioral health services including, but not limited to, advertising to enrollees and the general public, to ensure accuracy and completeness of information provided. This shall include communications and representations regarding the ability of enrollees to obtain individual and group behavioral health therapy, the ability of enrollees to obtain referrals to external contracted providers and out-of-network providers, and regarding alternatives to behavioral health therapy such as classes and smartphone applications. This shall also include information about changes the Plan will implement as the result of this Settlement Agreement and Corrective Action Plan and will also include review of communications to enrollees made by the Medical Groups and external contracted providers. (Health & Saf. Code, § 1360, subds. (a) & (a)(2).)

The Plan will review and, where required, file with the Department, all member-facing communication relating to behavioral health. The Plan's review will include, but not be limited to, identifying opportunities to correct for accuracy, completeness, and consistency across various platforms (*e.g.*, in writing, distributed in materials, on kp.org).

A. Communications to Members and General Public Regarding Behavioral Health Improvements

The Plan is designing a comprehensive communication strategy to inform members and the general public about the significant changes the Plan has made to address the deficiencies outlined in the Settlement Agreement and institute transformative improvements to Kaiser Permanente's behavioral health services.

The communication strategy will provide concrete, accurate, and clear updates regarding expanded resources to support member awareness and promote a better understanding of the availability of behavioral health services and how to access care. The information will be communicated through focused multimodal media and supported by digital tools to facilitate access.

B. Comprehensive Review of Plan Communications Regarding Behavioral Health Services

The Plan is in the process of conducting a comprehensive review of all direct member communications, advertising, policies and procedures, and staff training documentation to assess, update, and streamline communications to members and the general public regarding behavioral health services. The review is focused on the accuracy and completeness of behavioral health information on KP.org, information sent to directly members electronically or in hard copy, and printed materials available in clinics. The Plan is additionally evaluating training materials for staff and providers to confirm accuracy on such topics as accessing behavioral health services, the scope of services available, covered benefits, referrals, externally contracted providers, out of network providers, and continuum of care offerings including support classes and smartphone applications.

Communication reviews will be conducted by the behavioral health regional teams, the national marketing group and medical groups. Inaccuracies and gaps in content will be escalated to the BHQOC and health plan leadership to make necessary changes. Revised materials will be filed with the Department, as required.

C. Review Communications

The Plan is developing a process to evaluate all communications to members concerning behavioral health.

First, in connection with provider communications to members, including Medical Group and external providers, the Plan will develop a sampling methodology to review written and electronic member-facing communications. The reviews will take into account provider volume, geographic representation, demographics including age, race and gender, and will be both statistically significant and randomly selected. The Plan's regional behavioral health teams will regularly review materials and escalate any inaccuracies or areas for alignment for corrective action. Second, the Plan will audit Plan communications to members, including new member orientation materials, articles, resources, and benefits.

The Plan will take a comprehensive look at the frequency and redundancy of total member-facing communications, whether originating from the Plan or providers. This evaluation will include clinical surveys, member satisfaction surveys, and appointment reminders. The goal of this evaluation is to take a critical look at which communications are necessary, which may be redundant, and identify opportunities to streamline member touchpoints.

Finally, in connection with member and public-facing advertising, the Plan will confirm the accuracy and completeness of behavioral health information provided in advertising materials.

VIII. Corrective Action Area No. 8 – Continuous Detail and Comprehensive Review

In connection with CAA 8, addressing Continuous Detail and Comprehensive Review, the Settlement Agreement confirms the Plan's commitments as follows:

> ***The Plan shall engage in a systemic evaluation of all existing programs, processes, mechanisms, and policies and procedures by which enrollees' access or receive behavioral health services, including but not limited to Connect 2 Care, eConsult, Tridiuum, Tapestry, Ableto, and VADAPT. In addition, the Plan shall engage in a systemic evaluation of how enrollees access urgent behavioral health services, including the availability of the Medical Groups and external contracted providers to offer urgent and emergent behavioral health services. The Plan shall also continuously review whether the Medical Groups are appropriately performing the delegated services, compliant with the Knox Keene Action and regulations promulgated thereunder. (See Health & Saf. Code, §§ 1367, subd. (j), 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subd. (a)(3).).***

Kaiser Permanente is committed to offering a behavioral health care services program that is high-quality, comprehensive, and accessible to all members. Kaiser Permanente's system of care

has a track record of nation-leading outcomes for medical and preventative care. Consistent with that track record, the Plan's goal is similarly to lead in behavioral health treatment.

As this CAWP demonstrates, the Plan is committed to continually monitoring and evaluating its behavioral health service offerings, pathways into care, performance, quality, and all other elements impacting member experience. This commitment supports the Plan's efforts to transform its behavioral care system to meet members' behavioral health needs now and into the future.

In this section, the Plan highlights three workstreams, focused on (1) comprehensive evaluation of behavioral health including all programs, processes, mechanisms, network providers and policies and procedures; (2) continuous review of clinical offerings and quality; and (3) systemic evaluation of how members access urgent behavioral health services and higher acuity treatment.

A. Comprehensive Evaluation of Behavioral Health

The Plan's regional behavioral health teams will be conducting comprehensive, systemic and continuous reviews of all processes, mechanisms, and policies and procedures by which members access or receive behavioral health care services. As described in Section I – CAA 1 – the Plan has and continues to strengthen its infrastructure to support continuous, comprehensive, ongoing oversight and interventions to meet member behavioral health needs. The improved infrastructure and oversight activities will include (1) data analytics to ensure high reliability, (2) direct access and independent data analysis to conduct more effective oversight, (3) expanded scope and number of chart audits to gather findings that are reflective of its membership and to increase insight into whether treatment plans are based on members' individual needs, and (4) focused quality visits (in-person and virtual) to gain insights into member experience within the behavioral health ecosystem (shown below).

The behavioral health teams are focused on oversight of timely access, member experience, and level of care. For example, the Plan's behavioral health teams will conduct deep dives into triage and intake process improvements, member complaints and grievances, as well as patient satisfaction surveys and associated data for all programs. The teams will also be reviewing recommendations for various modalities and frequency of treatment to identify any trends and report findings to BHQOC.

In addition to its continuous review and actions, the Plan's regional behavioral health teams will implement a holistic and comprehensive review of the entire behavioral health services programs, its design, performance on quality and access metrics where applicable, and member satisfaction. This review will occur at least annually and will be updated for progress at least quarterly. The behavioral health teams will evaluate results from actions included in this plan, such as the streamlined pathway to connect members with the right care that will be implemented to perform key functions Connect 2 Care accomplishes today. The team's efforts will evaluate whether changes are working as intended and improving the member experience. These reviews will incorporate findings and insights obtained from all oversight actions outlined in the CAWP, including analyses of complaint and grievance data, access and network data, reviews of treatment plans to ascertain whether they are based on members' individualized needs, and a comprehensive assessment of the member experience.

The teams will capture the holistic assessment of behavioral health programs in a summary report. The summary report will include key performance indicators, the implementation status of actions outlined in the CAWP, and evaluate progress toward the Plan's improvement and oversight goals. The teams will document risks and develop and implement actions to mitigate the risks identified or to course correct if the Plan is off track in achieving its goals.

The quarterly summary reports will include Medical Group performance on key indicators, significant accomplishments, opportunities for improvements, and actions taken pursuant to the CAWP. They will include data on access monitoring, network capacity, referrals, member satisfaction, complaints and grievances, and findings from chart review across the Plan's entire network. The summary reports will also contain qualitative and where applicable quantitative status updates on key actions. For example, qualitative updates may include changes to policies and procedures and committee enhancements. Quantitative updates may include progress towards established targets such as access and network capacity.

The behavioral health teams will leverage the ongoing reviews referenced across the CAWP that assess whether the Medical Groups are overseeing and delivering care to members consistent with both Kaiser Permanente's mission and applicable laws and regulations. These teams' review will focus on the Medical Groups' role in care delivery, network management, contracting, and other key activities. The Plan will employ expanded direct access to data and its improved line of sight into the member experience to capture a holistic snapshot of medical group performance. Summary reports will reflect findings, opportunities, and areas of improvement regarding Medical Group performance as a direct care provider as well its management of the externally contracted network. Any opportunities or gaps will be addressed in accordance with the Plan's review, assessment, and escalation pathways (including those described in Section I – CAA1 – Oversight). The Plan will share opportunities, gaps, and any corrective actions with the Medical Groups.

Based on the findings in the summary report including findings relating to medical group, the regional teams will develop a comprehensive plan for the following year that identifies specific goals, opportunities for improvement, and outlines refinements and actions to continue evolving Kaiser Permanente's behavioral health programs. The annual plan will also outline areas of the system that will be the subject of deeper dives and the schedule and methodology for conducting these targeted, intensive reviews. The annual plans will be developed in consultation with the Medical Groups and will be reviewed by Plan leadership and the BHQOCs.

Regional behavioral health teams will monitor the progress of annual plans and document their assessment in the quarterly summary report that is shared with Plan leadership and with the appropriate health plan committees. The Plan leadership and committees will evaluate performance to identify opportunities for improvement, progress toward goals to ensure the Plan is taking necessary steps to achieve the transformation of behavioral health.

Consistent with the Plan's commitment to transformational change of behavioral health and to ensuring member needs are effectively met, it will take all necessary actions, to promptly address problems as they emerge and achieve implementation of improvement plans.

B. Systemic Review of Clinical Offerings

The Plan will conduct ongoing systemic reviews of clinical service offerings, to evaluate quality standards for behavioral health programs and service offerings. These standards establish the rubric for the Plan's evaluation efforts and provide consistency in evaluating service offerings. The standards will be used to determine the effectiveness of service offerings, and the extent to which they are meeting member needs. To put these standards into action, the Plan will create a standard program evaluation tool within the BHQOC.

The BHQOC provides direct oversight for behavioral health clinical programming. The BHQOCs will produce an annual schedule for evaluation of specific behavioral health service offerings. The schedule will specify which behavioral health programs (e.g. anxiety and depression care management, eating disorder programming, gender care services, substance use disorder) are subject to review and the associated timing of the review. The BHQOC will consider the following factors in determining which programs to review: volume, quality indicators, and duration. The BHQOCs will identify opportunities or gaps in programs or service offerings. Any opportunities or gaps will be addressed in accordance with the Plan's review, assessment, and escalation pathways and shared with the Medical Groups as part of continuous feedback. The Plan will focus on specific changes and actions that tie to performance improvement, and revisit and update these actions if they are not yielding needed results. If there is a need to expand services or make other adjustments to address emerging trends, the Plan will take action to meet member needs.

Specific programs reviewed may include intensive outpatient programs, Achieving Depression and Anxiety Patient-centered Treatment Outcomes (ADAPT), inpatient psychiatric bed capacity, and intensive case management, among other programs. Reviews will be comprehensive and include both existing and new programs. Cadence of program report outs to the BHQOCs will be determined based on standards developed for program oversight.

C. Systemic Evaluation of Access to Urgent and Emergent Care

The Plan is, and will continue, to assess and anticipate the ways in which members seek urgent behavioral health care through access points such as walk-ins, telephone calls, outreach to providers, outreach to crisis lines, and referrals from clinical care teams. These assessments include a systemic evaluation of access to urgent services, including the availability of Medical Groups and external contracted providers to meet urgent and emergent care needs. The Plan is also evaluating the Southern California behavioral health crisis line for urgent or emergent needs, and its Northern California after-hours call center that performs a similar function.

When individuals experience behavioral health emergencies, they may seek emergency treatment from the nearest emergency department. The Plan is, and will continue to assess, how its members seek emergency care, including from Plan and non-Plan Affiliated emergency departments. The Plan's ability to coordinate appropriate care and support discharge planning with non-Plan hospitals is necessarily dependent on prompt communication from emergency providers. The Plan is evaluating ways to both streamline and encourage care coordination for this population. The Plan also notes its efforts in these areas would be substantially supported by implementation of Proposition 1 and the expansion of bed capacity and treatment options to serve members with sub-acute needs.

The Plan regularly and continually assesses its available supply of inpatient beds and 23-hour crisis services against demand. Given the severe shortage of inpatient bed capacity in the state of California, the Plan's efforts to track and meet demand are extensive and continuous. The Plan is constantly pursuing providers and facilities to add to its network of inpatient beds, residential treatment, and crisis stabilization units to meet members' acute care needs. The Plan is particularly focused on expanding its behavioral health network in areas where supply is constrained, such as pediatrics, geriatrics, and eating disorders. Given the lack of capacity, the Plan will be conducting a thorough evaluation of treatment options. It is actively exploring building its own capacity and pursuing innovative partnerships to expand treatment options for urgent and acute care needs.

In connection with its systemic review of urgent and emergent care access, the Plan will review and evaluate all available data including findings from chart reviews, results from audits, quality metrics, and member experience, to assess whether timely, quality care is being provided. This review will include a comprehensive analysis of the Plan's supply and demand dashboard, which reflects available treatment capacity against demand for services. The Plan will also evaluate how members access urgent and emergency behavioral health services and ensure workflows are documented and monitored for ongoing regulatory compliance.

The regional behavioral health teams will report the results of their systemic evaluation through reporting to the appropriate regional committee. The Plan will proactively identify trends and opportunities for further action. In addition, to the extent the Plan's chart audits reveal opportunities for improvement in connection with urgent or emergent care access, this information will be reported to the appropriate regional committee for action.

D. Conclusion

These holistic, comprehensive, systemic assessments in addition to the Plan's detailed oversight and accountability processes, as described throughout the CAWP will ensure behavioral health services are delivered in compliance with all regulatory requirements, including SB 855, SB 221, continuity of care regulations, and parity laws, as well as best practices. They will enable Kaiser Permanente to transform its behavioral health services program to become a national leader in behavioral health for the benefit of its members.

Exhibit A

Governance Structure

Health Plan Governance Structure
Executive Sponsors

Group President & COO Care Delivery Kaiser Foundation Health Plan, Inc. & Hospitals	Regional President Southern California	Regional President Northern California
Senior Vice President & Chief Legal Officer Kaiser Foundation Health Plan, Inc. & Hospitals	Senior Vice President, Clinical Services Southern California	Senior Vice President, Clinical Services Northern California

Core Leadership Team

VP, Behavioral Health & Wellness Northern California	VP, Behavioral Health & Wellness Southern California	VP, Assoc. Chief Medical Officer Program Office	VP, BH & Specialty Services Northern California
VP, Safety, Quality & Reg Services Northern California	VP, Safety, Quality & Reg Services Southern California	VP, Member Experience Southern California	VP, (Interim) Member Experience Northern California

Legal, Regulatory & Compliance: VP, Enterprise Regulatory Services, VP, Health Plan Compliance, VP, Southern California Regional Counsel, VP, Northern California Regional Counsel, National Legal Senior Counsel, National Legal Senior Counsel, Senior Director, Enterprise Regulatory Services, Executive Director, Senior Managing Counsel, Commercial Compliance
Behavioral Health Leads: Executive Director of Behavioral Health & Wellness, Northern California and Executive Director of Behavioral Health & Wellness, Southern California
Consultant: Outside Consultant

Medical Group Behavioral Health Leadership
Executive Sponsors

CEO The Permanente Medical Group	CEO Southern California Permanente Medical Group
Associate Executive Director, Psychiatry The Permanente Medical Group	Regional Medical Director, Ops Southern California Permanente Medical Group

Core Leadership Team

Chair, Psychiatry The Permanente Medical Group	Psychiatry The Permanente Medical Group	Regional Administrative Leader The Permanente Medical Group
Regional Chief of Psychiatry Southern California Permanente Medical Group	Svc Line Leader Behavioral Health Southern California Permanente Medical Group	Behavioral Health Executive Leader Southern California Permanente Medical Group

Legal, Regulatory & Compliance: The Permanente Medical Group Chief Legal Counsel, The Permanente Medical Group Assistant General Counsel, Southern California Permanente Medical Group Chief Legal Counsel, and Southern California Permanente Medical Group Senior Counsel
Behavioral Health Leads*:* Regional Behavioral Health Clinical Director, Southern California Permanente Medical Group and Regional Behavioral Health Clinical Director, The Permanente Medical Group

Exhibit B

Accountable Executive Index

Corrective Action Area #1 – Oversight	**Title**	**Region**
	SVP, Clinical Services	Southern California
	SVP, Clinical Services	Northern California
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Quality, Safety & Regulatory Services	Southern California
	VP, Quality, Safety & Regulatory Services	Northern California
	VP, Behavioral Health & Specialty Care	Northern California
	VP, Compliance	Statewide
	Executive Director, Commercial Compliance	Statewide
	VP, Compliance Officer	Southern California
	VP, Compliance Officer	Northern California

Corrective Action Area #2 – Access	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Quality, Safety & Regulatory Services	Southern California
	VP, Quality, Safety & Regulatory Services	Northern California
	VP, Behavioral Health & Specialty Services	Southern California
	VP, Consumer Experience	Northern California
	Associate Executive Medical Director	Southern California
	Associate Executive Medical Director	Northern California
	Asst Regional Director, Behavioral Health Line Leader	Southern California

	Title	Region
	Regional Behavioral Health Director	Northern California
	Director of Regional Mental Health	Southern California
	Executive Administrative Leader	Northern California
	Executive Administrative Leader	Northern California
Corrective Action Area #3 – Networks & Referrals	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	Regional Health Plan Advisor	Southern California
	Regional Health Plan Physician Advisor	Northern California
	VP, Behavioral & Specialty Services	Southern California
	VP, Quality, Safety & Regulatory Services	Northern California
	VP, Quality, Safety & Regulatory Services	Southern California
	VP, Consumer Experience	Northern California
	Title	**Region**
	Asst Administrator – Operations	Southern California
	Managing Director, Outside Medical Contracts	Southern California
	Director, Regional Administrator, Outside Referrals	Northern California
	Regional Administrator, Medical Services Contracting	Northern California
	Asst Regional Director, Behavioral Health Line Leader	Southern California
	Regional Behavioral Health Director	Northern California
	Director of Regional Mental Health	Southern California
	Executive Administrative Leader	Northern California
	Executive Administrative Leader	Northern California

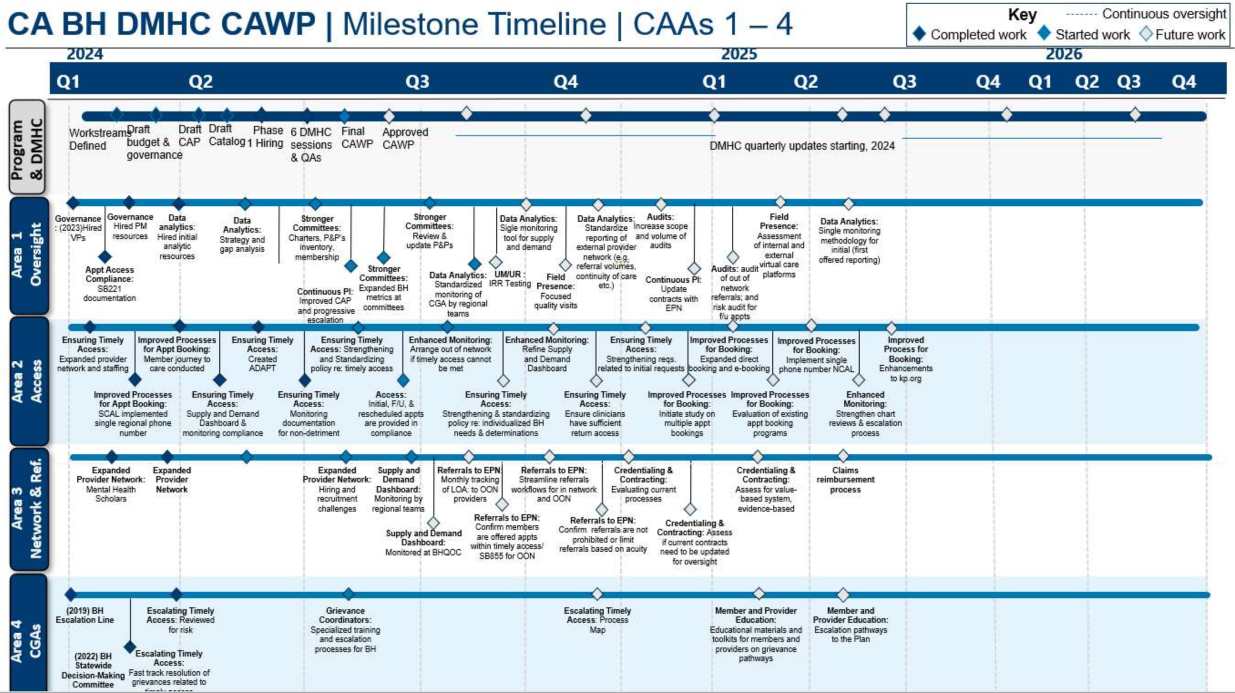
Corrective Action Area #4 – Grievances & Appeal	Title	Region
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Member Relations	Statewide
	VP, Consumer Experience	Southern California
	VP, Quality, Safety & Regulatory Services	Southern California
	VP, Quality, Safety & Regulatory Services	Northern California
	VP, Consumer Experience	Northern California
	Regional Physician Advisor	Northern California
	Regional Physician Advisor	Northern California
Corrective Action Area #5 –Strike Contingency Plan	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Support Services	Southern California
	VP, Support Services	Northern California
Corrective Action Area #6 – Parity	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Consumer Experience	Southern California
	VP, Consumer Experience	Northern California
	VP, Health Plan Compliance	Statewide
	Executive Director, Commercial Compliance	Statewide
	VP, Behavioral Health & Specialty Services	Southern California
	Regional Health Plan Physician Advisor	Northern California
	Regional Health Plan Physician Advisor	Northern California

	Title	Region
	Asst Regional Director, Behavioral Health Line Leader	Southern California
	Director Regional Mental Health	Northern California
	Executive Administrative Leader	Southern California
	Executive Administrative Leader	Northern California
Corrective Action Area #7 – Member Communication	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Communication & Media Services	Southern California
	VP, Consumer Experience	Southern California
	VP, Communications	Northern California
Corrective Action Area #8 – Continuous Detail & Comprehensive Review	**Title**	**Region**
	VP, Behavioral Health & Wellness	Southern California
	VP, Behavioral Health & Wellness	Northern California
	VP, Behavioral Health & Specialty Services	Southern California
	VP, Quality, Safety & Regulatory Services	Northern California
	VP, Quality, Safety & Regulatory Services	Southern California
	VP, Consumer Experience	Northern California
	VP, Compliance	Statewide
	Executive Director, Commercial Compliance	Statewide
	Associate Executive Medical Director	Southern California
	Associate Executive Medical Director	Northern California
	Asst Regional Director, Behavioral Health Line Leader	Southern California
	Director of Regional Mental Health	Northern California
	Executive Administrative Leader	Southern California
	Executive Administrative Leader	Northern California

Exhibit C

Timelines and Detailed Plans

CAA Area Milestone Timeline



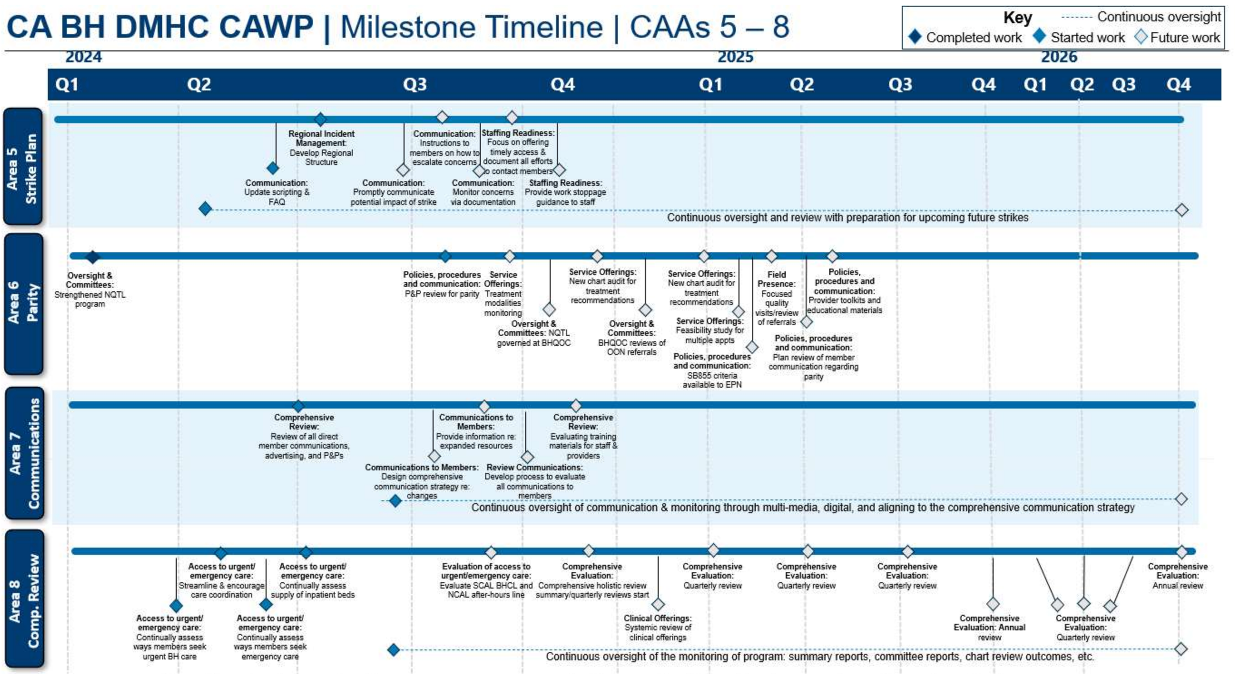


Exhibit D

Summary of Improved Oversight

Key Area	Prior HP Oversight	Current/Future HP Oversight	Notes
Oversight Infrastructure: Plan Behavioral Health Teams	Limited infrastructure to support Behavioral Health oversight	HP hired more than twenty staff, including Vice Presidents, Executive Directors, program managers, consultants, and data analysts to provide continuous oversight	[Reference: Settlement Agreement CAA #1]
Entry to Care & Member Experience			
Member Awareness of Behavioral Health Services	Information on KP Behavioral Health services shared through multiple modes; Health Plan was not tracking and updating communications timely	Redesigned communications to members, including KP.org, text, email, hard copy messages, and external communications, and enhanced processes for monitoring and updating communications	[Reference: Settlement Agreement CAA #2]
Entry to Care	Many ways to enter Behavioral Health services; entry to care inconsistent without any HP oversight	Ensure single phone number for both regions, smooth referral pathways, and detailed review of workflows for crisis services and ED evaluation and admissions	Entry to Care: Current & Future State [Reference: Settlement Agreement CAA #2]
Member Experience in Care Setting	HP oversight was not specific to Behavioral Health; only reviewed as one of many services	Explore real-time post-visit member survey (via text, email), meet with customer groups, joint meetings with PMGs on customer engagement survey results, and commission comprehensive member journey assessment	[Reference: Settlement Agreement CAA #2]

Complaints and Grievances	HP is responsible for complaints and grievance process, limited oversight performed to respond to trends programmatically	With new statewide grievance committee, HP is working intensely to evaluate complaints and grievances for specific resolution and trends indicating needed systemwide changes	[Reference: Settlement Agreement CAA #4]
Significant Patient Events	When there is a significant event (e.g., allegation of patient abuse, data breach of privacy), HP representatives are informed, and review process includes both HP and Medical Group	HP continues to investigate these events and develop appropriate responses. New oversight infrastructure will include data collection and review to identify any trends and need for programmatic improvements	[Reference: Settlement Agreement CAA #2]
Data Analytics & Reporting			
Full Range of Behavioral Health Services	No attention to full Behavioral Health ecosystem	Oversee full range of services through data analytics on utilization trends, member experience, and access. Continuous evaluation of programs and services	Behavioral Health Ecosystem [Reference: Settlement Agreement CAA #1 and #8]
Supply & Demand Dashboard	PMGs provided data to HP, but no processes in place to monitor and track what was received	HP reviews PMGs' supply and demand dashboard on monthly basis to assess supply and demand trends; new metrics added to supply and demand dashboard	Supply & Demand Dashboard Details [Reference: Settlement Agreement CAA #1, 2]
Access to Initial & Follow-up Therapy	Reporting through Access Committee limited to initial appointments	Reporting includes initial and follow-up by Medical Center Area (MCA), and trends in emergent and urgent care access	

Volume of Internal Therapists & Subcontractors	HP function supports all hiring and onboarding, so all information is accessible, but no oversight performed from regulatory oversight team	New HP Oversight infrastructure oversees this through review and evaluation of supply and demand dashboard	
Behavioral Health Escalation Line	HP launched a toll-free behavioral health customer service line in 2019 to address access issues and member concerns, however, limited data reviewed on its effectiveness	Escalation line metrics, including volume, types of concerns, calls escalated, calls resolved, etc. reported through BHQOC; Actively monitored for trends and improvement opportunities	
Claims Adjudication	HP function performs claims adjudication, but no regulatory oversight performed and no attempt to tie claims data to performance	New HP BH oversight infrastructure includes responsibility to assess claims data to determine compliance and effectives of BH program for members; critical ability to assess if member needs are met	
Quality of Care			
Chart Review	Small volume of chart reviews for quality oversight; chart reviews started in 2023 for SCAL & NCAL	New HP BH Oversight infrastructure enables expansive chart review to include ability to spot trends and patient-specific issues; Regular reports on findings	
External Network Oversight	No structure in place for overseeing external network data and limited data available	Expanded reporting on external network, including number of active providers and contracts, referral volumes, time to initiation report, first offered reporting where feasible, member connectivity rate, and volume data on external pathways	