

DEPARTMENT OF
Managed
Health Care



**OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

FINAL REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE HEALTH PLAN

DATE OF FINAL REPORT: JUNE 12, 2017

**Final Report of a Routine Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Health Plan
June 12, 2017**

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EXECUTIVE SUMMARY

On December 15, 2015, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc. (Kaiser Permanente or the Plan) that its Routine Survey had commenced and requested the Plan submit information regarding its health care delivery system for both full service and behavioral health services. The survey team conducted the Southern California onsite survey from May 16, 2016 through May 20, 2016 and on March 30, 2017. The Department conducted the Northern California onsite survey from June 20, 2016 through June 24, 2016.

While onsite the Department reviewed plan documents and files for both full service and behavioral health services. For the Full Service survey, the Department’s review period for files was from March 1, 2014 through January 15, 2016. For the Behavioral Health survey, the Department’s review period for files was from December 1, 2014 through January 1, 2015.

The Department assessed the following areas:

- Quality Assurance**
- Grievances and Appeals**
- Access and Availability of Services**
- Utilization Management**
- Continuity of Care**
- Access to Emergency Services and Payment**
- Prescription (RX) Drug Coverage**
- Language Assistance**

The Department identified **six (6)** deficiencies during the current Routine Survey. The 2016 Survey Deficiencies table below notes the status of each deficiency.

2016 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE (QA) Southern California – Behavioral Health	
1	The Plan does not consistently take effective action to improve care where deficiencies are identified, Plan follow-up where indicated, or monitor whether the provision and utilization of services meets professionally recognized standards of practice. Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(3).	Not Corrected

	QUALITY ASSURANCE (QA)/ACCESS AND AVAILABILITY OF SERVICES Southern and Northern California – Behavioral Health	
2	<p>The Plan’s Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.</p> <p>Section 1370; Rules 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(D); Rule 1300.70(b)(2)(G)(3); and Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3).</p>	Not Corrected
	GRIEVANCES AND APPEALS Southern and Northern California – Full Service and Behavioral Health	
3	<p>The Plan does not immediately notify enrollees filing expedited grievances of their right to notify the Department of their grievance.</p> <p>Section 1368.01(b); Rule 1300.68.01(a).</p>	Not Corrected
4	<p>For expedited grievance decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guideline used by the Plan and the clinical reasons for the decision.</p> <p>Section 1368(a)(5); Rule 1300.68(d)(4).</p>	Not Corrected
	UTILIZATION MANAGEMENT Southern and Northern California – Full Service and Behavioral Health	
5	<p>The Plan does not consistently consider the “reasonable person” standard when evaluating the medical necessity of emergency services.</p> <p>Section 1371.4(a)-(c); Rule 1300.67.2(c).</p>	Not Corrected
6	<p>For decisions to deny emergency services based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guidelines used, and the clinical reasons for the decision.</p> <p>Section 1367.01(h)(4).</p>	Not Corrected

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.¹ At least once every three years, the Department conducts a Routine Survey that covers major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Assurance – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within required timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.

Prescription Drugs – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on December 19, 2016. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action.

¹ The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department making the Final Report public.

PLAN BACKGROUND

Kaiser Permanente obtained its Knox-Keene license in 1977. The Plan covers over 7,000,000 enrollees in California, primarily through arrangements with three separate entities. The Plan contracts with The Permanente Medical Group (TPMG), Southern California Permanente Medical Group (SCPMG), and Kaiser Foundation Hospitals (KFH). TPMG and SCPMG are multi-specialty physician organizations that provide, and arrange for the provision of medical services to Plan enrollees.

In addition to its contracted medical groups, for the provision of behavioral health services the Plan has entered into contracts with other entities. In Northern California the Plan contracts with Beacon Health Options² and Magellan Health Services of California, and in Southern California the Plan contracts with Beacon Health Options, Windstone Behavioral Health and Psychcare. Set forth below is a table with the dates Kaiser Permanente entered into contracts with these entities:

Northern California

Beacon Health Options	June 23, 2014
Magellan Health Services of California	November 1, 2015

Southern California

Beacon Health Options	March 1, 2016
Windstone Behavioral Health	June 15, 2006
PsychCare, Inc.	June 15, 2011

² Beacon Health Options was formerly known as Value Options.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On December 19, 2016, the Plan received a Preliminary Report and was instructed to:

- (a) Develop and implement a corrective action plan (CAP) for each deficiency, and
- (b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY ASSURANCE (QA) Southern California – Behavioral Health

Southern California Region

Deficiency #1: **The Plan does not consistently take effective action to improve care where deficiencies are identified, Plan follow-up where indicated, or monitor whether the provision and utilization of services meets professionally recognized standards of practice.**

Statutory/Regulatory Reference(s): Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(3).

Assessment: In a review of Potential Quality Issue (PQI) files, the Department found that the Plan did not follow-up on its CAPs to ensure that it implemented CAPs, and that the CAPs effectively addressed the quality problems.

Rule 1300.70(a)(1) requires the Plan to ensure "that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated." Rule 1300.70(a)(3) requires the Plan's QA program to "monitor whether the provision and utilization of services meets professionally recognized standards of practice."

Plan Policy, *Peer Review and Evaluation of Licensed Independent Practitioner Performance*, describes actions the Plan will take to improve care when significant issues are confirmed in PQI files. For instance, on page 7, the policy states that the Plan will assign Practitioner Performance Scores (P Scores) to categorize its assessment of the provider's performance on cases reviewed as PQIs and "notify and provide feedback to practitioner" in PQI cases leveled at P1 (minor opportunity for improvement and/or no consensus reached). For cases involving a level of P2 (significant opportunity for improvement and/or care deemed inappropriate), the Plan will develop a "Practice Improvement Plan (PIP) with practitioner within 60 days of case attestation and track to identified closure date." Further, if a system score (S score) is needed, the Quality Department and department administrator/manager or designee will

“describe potential system issues, whether or not resolved, on the Peer Review Worksheet and refer to the Quality Department.”

File review

The Department’s review of 49 PQI files revealed that when the Plan implemented a CAP, it did not sufficiently address the quality issues. The Department determined that in the 14 cases where the Plan determined a CAP was needed, the Plan did not verify that the CAP was implemented in seven³ (50%) cases, and the Plan did not assess the effectiveness of the CAP in eight⁴ (57%) cases.

The following are case examples illustrating that the Plan verified neither that the CAP was implemented nor assessed the effectiveness of the CAP:

- **File #3:** This case involved a delay in treatment for individual psychotherapy. The enrollee was taking psychotropic medication for diagnoses of depression and anxiety beginning November 2014, but was not scheduled to meet with a clinician for individual psychotherapy until March 2015. Documentation identified the following CAP: “reduce access wait time by group referral and outside contracts. The hiring of FTEs [full-time equivalent employees] is in progress and includes two new physicians and seven pending therapist requisitions. Educate staff of protocols, consistent messaging and criteria for outsourcing.” File documentation neither included verification that this CAP was implemented nor an assessment of the effectiveness of the CAP.
- **File #15:** This case involved an enrollee who was unable to make a timely follow-up appointment with her psychotherapist. The enrollee had to schedule her next appointment three weeks subsequent to her last session, although the psychotherapist instructed her to schedule an appointment in two weeks. Documentation identified the following CAP: “educate therapist as to the established procedure utilized to address access; contact patient to offer outsourcing option available for more frequent sessions.” Documentation in the file neither included verification that the CAP was implemented nor an assessment of the effectiveness of the CAP.
- **File #17:** This case involved an enrollee diagnosed with several chronic medical conditions, bipolar I disorder and substance use disorder. The enrollee was psychiatrically hospitalized for suicidal ideation on July 6, 2015, at a contracted facility. The Plan’s investigation confirmed two quality issues. The Plan determined that there was a delay in continuing the enrollee’s psychiatric medications until the provider evaluated the enrollee, and confirmed an inability of the nurses to clearly identify the enrollee’s home medication from the Plan’s transfer documentation. The following CAPs were identified: (1) re-orient nursing staff in how to assess Plan transfer documentation for home medication lists; (2) obtain medical staff review to assess how improvements can be made to ensure timely ordering of admission medications; and (3) assess the hand-off process

³ File #1, File #3, File #15, File #17, File #35, File #40, File #47.

⁴ File #1, File #3, File #15, File #17, File #35, File #38, File #40, File #47.

and transfer process and implementation changes that will more clear identify home medication upon enrollee transfer. File documentation neither included verification that the CAP was implemented nor an assessment of the effectiveness of the CAP.

TABLE 1
Plan Handling of CAPs
Implementation and Effectiveness

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI Files (Behavioral Health) where CAP was assigned	14	Plan verified CAP was implemented	7 (50%)	7 (50%)
PQI Files (Behavioral Health) where CAP was assigned	14	Plan assessed effectiveness of CAP	6 (43%)	8 (57%)

Conclusion: For the Plan’s QA program, section 1370 requires the Plan to establish procedures for continuously reviewing quality of care, the performance of medical personnel, and the utilization of services and facilities. Rule 1300.70(a)(1) requires the Plan to identify problems, take effective action to improve care where deficiencies are identified, and plan follow-up where indicated. Rule 1300.70(a)(3) requires that the Plan’s QA program must monitor whether the provision and utilization of services meets professionally recognized standards of practice. The CAPs assigned by the Plan did not consistently address all identified problems, and the Plan did not verify that all CAPs were implemented and effective in addressing identified problems. Therefore, the Department found the Plan in violation of these statutory requirements.

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan presented the following response to address the deficiency:

The Plan has reviewed three Southern California files identified by the Department in the Preliminary Report [File #3, File #15, and File #17] and the Plan ... is implementing the following corrective actions:

- i. In the first quarter 2017, implementation of training for Southern California Quality Directors and appropriate staff on the validation and assessment of PQI corrective action plans;

- ii. In the second quarter 2017, Southern California Department Administrators and appropriate quality staff will receive an educational training session to reinforce their responsibility to provide necessary documentation in MIDAS [the Plan's information system], to show that action plans were implemented and the effectiveness of the corrective action was assessed; and
- i. In the third quarter 2017, the Plan's Health Plan Regulatory Services Department (HPRS) will conduct a follow-up focused audit of a sampling of the Southern California PQI cases reviewed by the Quality Department to assess the effectiveness of this CAP.

Final Report Deficiency Status: Not Corrected

The Plan provided a CAP to address this deficiency by proposing staff training for the first and second quarters of 2017 and by conducting a focused audit in the third quarter of Southern California PQI cases to assess the effectiveness of the Plan's CAP. However, the Plan did not provide any of the training materials proposed for the staff training nor did it describe the methodology that would be used to conduct the focused audit.

Within 60 days of the issuance of this report, the Plan shall submit a supplemental response that includes a status report of the Plan's progress, training materials and audit methodology, if completed. Finally, the corrective measures identified by the Plan will take time to implement and are ongoing. The Department will conduct a Follow-Up Survey, including file review, within 18 months from the date the Final Report is issued to the Plan.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

QUALITY ASSURANCE (QA) /ACCESS AND AVAILABILITY OF SERVICES **Southern and Northern California – Behavioral Health**

Deficiency #2: **The Plan's Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.**

Statutory/Regulatory Reference(s): Section 1370; Rules 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(D); Rule 1300.70(b)(2)(G)(3); and Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3).

Deficiency Background: During the 2012 Routine Behavioral Health Survey,⁵ the Department cited the Plan for failure in its QA responsibilities, to ensure that effective action was taken to improve care where deficiencies were identified in service elements, including accessibility, availability, and continuity of behavioral health care (deficiency

⁵ [Kaiser Routine Survey Reports](#)

#3). The Plan submitted a corrective action plan in response to the Preliminary Report. The Department determined this deficiency was uncorrected at the time of the Final Report issued on March 18, 2013, and subsequently determined the deficiency remained uncorrected at the time of the Follow-Up Review conducted in the Fall of 2013 through Spring, 2014 as discussed in the Follow-Up Report issued to the Plan on February 13, 2015. As part of the Department's Follow-Up Review for deficiency #3, it reviewed the ability of enrollees to obtain follow-up appointments. The Department concluded enrollees faced barriers when obtaining appointments for behavioral health services including follow-up appointments. With respect to deficiency #3, the Department concluded in the Follow-Up Report that the Plan must implement a process for regularly tracking availability and timeliness of initial and follow-up appointments and take effective and timely action when problems are identified.

Assessment:

1. The Plan does not take effective and timely action when problems are identified for initial behavioral health appointment availability.

In order to address concerns regarding enrollee access to initial appointments raised in the 2012 Routine Survey, the Plan began tracking initial appointment access under an "Appointments within Standard" methodology. This measure reports, by Plan department and Plan medical center area, the percentage of initial appointments with wait times falling within the timeframe applicable to each appointment type set forth in Rule 1300.67.2.2(c)(5). The Plan set its threshold for corrective action for any medical center that falls below 80% of initial appointments occurring within the standards set forth in Rule 1300.67.2.2(c)(5). If a substantial drop occurs from one month to the next, the Plan takes action prior to any medical center falling below 80%.

Based on the data in Table 2 (below),⁶ the Department determined that for the survey period, the Plan did not provide enrollees with timely access to initial appointments for behavioral health services or take effective action regarding these access problems when they were identified. While the Department acknowledges the Plan has significantly improved its compliance with regulatory timeframes,⁷ Table 2 demonstrates that several medical centers (identified as A-E in Table 2) had rates for initial behavioral health appointments well below the Plan's internal 80% compliance standard for

⁶ Table 2 represents data from a Plan document that tracks enrollee access to initial behavioral health appointments for physician and non-physician providers. The Department reviewed appointment information from four categories: 1) physician urgent 2) physician non-urgent 3) non-physician urgent 4) non-physician non-urgent. In addition, for those months where the table is blank, the Plan met its 80% threshold for access compliance.

⁷ The Plan has enhanced its tracking reports to include the new measure on *Percentage Initiated to Seen*, regularly produces and disseminates these reports, improved the timeliness of its implementation of corrective actions, systematized the monitoring of corrective actions to ensure effectiveness, and implemented committee structures to conduct ongoing review of appointment availability. The Plan has also implemented a variety of corrective actions as it deems appropriate for various medical centers including hiring of additional staff, use of contracted providers, adding hours/appointments to individual therapists' schedules and temporarily sending staff from one Plan medical center to another to assist with resolving backlogs.

multiple months. In some instances, the Plan fell well below its own 80% compliance standard for several months.

Table 2
Examples of Ongoing Non-Compliance in Initial Appointment Availability Timeframes – Behavioral Health Services

A – Kern					B – San Diego			
	Physician	Physician	Non-Physician	Non-Physician	Physician	Physician	Non-Physician	Non-Physician
2015	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent
Jan								
Feb								
Mar								
Apr								
May						61%		
Jun						59%		
Jul						61%		
Aug		59%		60%		72%		
Sep		54%		75%				
Oct		65%						
Nov		59%						
Dec		46%						

C – Fresno					D – S. Alameda			
	Physician	Physician	Non-Physician	Non-Physician	Physician	Physician	Non-Physician	Non-Physician
2015	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent
Jan								
Feb								
Mar								
Apr				71%				77%
May				51%				
Jun				66%				74%
Jul			78%*					
Aug								
Sep			70%					
Oct								
Nov								
Dec								

*fewer than 10 appointments measured

E – North Valley

	Physician	Physician	Non-Physician	Non-Physician
2015	Urgent	Non-Urgent	Urgent	Non-Urgent
Jan				
Feb				
Mar				
Apr				
May				
Jun				
Jul				
Aug				79%
Sep			73%	73%
Oct				67%
Nov				69%
Dec				

On this table, months with no entries were above the 80% threshold established by the Plan for identification of non-compliance.

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

As a result of the 2012 Routine Survey, the Plan was also required to implement a process for regularly tracking availability and timeliness of follow-up appointments and taking effective and timely action when problems were identified. During this survey, the Department requested the results of the Plan’s internal auditing of follow-up appointments. The Plan reported it had only recently developed, implemented and provided training for an internal audit process designed to measure the timeliness of its behavioral health follow-up appointments.⁸ After the Department was no longer on-site, the Plan provided some results from the Plan’s internal audit process. However, due to the short time period for which data had been available, and the small number of cases provided to the Department during the course of the survey, the Department determined there was insufficient evidence to verify whether the Plan was consistently compliant with follow-up appointment timelines across all medical centers. Further, based on the information reviewed by the Department during its survey of behavioral health appointments, the Department was unable to confirm whether the Plan had in fact achieved over 90% compliance which the Plan subsequently represented to the Department. Moreover, it was not clear whether the Plan had begun to incorporate the results of these audits into the oversight conducted by its access and quality assurance committees or whether it had used the results to implement CAPs where appropriate.

⁸ The Plan reported full implementation of the audit template was not completed until the end of 2015 in the Southern Region and the Spring of 2016 for the Northern Region.

Conclusion: Section 1370 requires that every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. In addition, Rule 1300.70(a)(1) requires the Plan's QA Program to document that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. During the current survey period, the Plan data demonstrated: 1) the Plan failed in some of its facilities to meet its internal 80% compliance standard for initial appointments during the survey period; and 2) the Plan did not ensure that providers offered enrollees appointments that met specified timeframes. In addition, during the current survey period, the Plan did not have a mechanism in place to ensure it provided timely follow-up appointments for behavioral health services. . Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan's Compliance Effort:

The Plan provided the following response:

1. The Plan does not take effective and timely action when problems are identified for initial behavioral health appointment availability.

In response to this aspect of the deficiency, the Plan responded as follows:

The Plan is committed to providing high-quality services and seeking ways to constantly improve. Overseeing and managing care is a dynamic process that fluctuates daily, as changes in demand and supply occur. The Plan respectfully submits that its policies, procedures, performance metrics, and quality improvement process enable the Plan to exercise robust oversight. Few, if any plans, maintain the same type of rigorous and granular access to performance data, to inform its oversight of quality and access. The Plan acknowledges the temporary access challenges that occurred at the medical centers (identified as A-E in Table 2) and the Plan takes these access issues seriously and continues to take steps to address challenges as they may arise.

Since the 2012 Behavioral Health survey, the Plan has implemented many interventions in an effort to improve access. In addition to dealing with the national shortage of behavioral health clinicians, the Plan also had to address a union corporate campaign (involving behavioral health therapists). During that time, while in regular communication with the Department, the Plan has implemented many interventions to enhance access, including but not limited to:

Short-term interventions implemented:

- Created additional appointments to compensate for unused slots and/or no show appointments
- Converted educational time, administrative time, or other indirect patient time

- to enrollee appointments
- Utilized telephone and/or video visits
 - Obtained assistance from other service areas
 - Added extra clinic time in the evenings or weekends
 - Increased the hours of per diem clinicians
 - Increased hours for physicians that want to work extra time
 - Cancel, reduce or move vacations or other leave as needed
 - Utilized psychiatrists to assist with initial therapy evaluations
 - Increased the use of external contracted providers. Both regions established contracts with large external behavioral health provider networks (in addition to many individual provider contracts in SCAL) and used them aggressively to improve access for enrollee in areas with access challenges
 - Expanded the role of the Primary care physician to help with medication appointments
 - Increased the productivity of clinicians

Long Term interventions implemented:

- Aggressively recruiting and hiring additional behavioral health clinicians. Recruiting efforts since 2011 reflect the following increase in behavioral health FTE's:
- Northern California:
 - In 2011, the Plan's Northern California behavioral health clinician FTE's totaled 982.57 (Total non-MD FTEs=764.20; total MD FTEs=218.67, total FTEs=982.97)
 - In 2016, the Plan's Northern California behavioral health clinician FTE's totaled 1365.32, **reflecting an increase of 382.75 FTE's since 2011.** (Total non-MD FTEs=1092.03, total MD FTEs=273.29, total FTEs=1365.32)
- Southern California:
 - In 2011, the Plan's Southern California behavioral health clinician FTE's totaled 559.2 (Total non-MD FTEs=395.8; total MD FTEs=163.4, total FTEs=559.2)
 - In 2016, the Plan's Southern California behavioral health clinician FTE's totaled 1,000.77, **reflecting an increase of 441.57 FTE's since 2011.** (Total non-MD FTEs=731.17 , total MD FTEs=269.60)
- Implemented a statewide access CAP template for medical centers to use to ensure that access CAPs have a uniform approach to handling access gaps as they occur.

In addition to the above interventions, the Plan stated it has contracted with reputable large external behavioral health providers, hundreds of solo external behavioral health providers and continues to seek ways to better address the challenges that all health plans are experiencing. The American Hospital Association white paper on the state of the behavioral health workforce predicts that by year 2030, if no workforce changes are made nationally, there will only be one geriatric psychiatrist for every 6,000 older Americans with mental illness. The Bureau of Health Professions estimates that in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312. Compounding this shortage is the fact that

in the current field of psychiatry, nearly 55 percent of providers are over the age of 55 and only 4 percent of the U.S. medical school graduates have been applying for residency training in psychiatry. The American Hospital Association describes the behavioral health workforce shortage as “daunting.” The Plan, and the community, recognizes the fact that the number of available providers in behavioral health is dwindling each year. The Department, Health Plans and providers must work together in order to explore new avenues for addressing these challenges.

The Plan concluded by stating that with the foregoing challenges in mind, the Plan continues to look for ways to improve, and has been working diligently and in cooperation with the Department’s Division of Plan Surveys and Division of Enforcement in its efforts to identify all viable options.

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

In response to this aspect of the deficiency, the Plan responded as follows:

The treatment plan audit process was in place during the survey

The Plan disagreed with the Department’s finding that its audit process concerning behavioral health follow up appointments was not in place during the survey review period. The Plan stated that, in fact, its audit process was implemented in both regions on January 1, 2016 with the training taking place in 2015. In addition, the Plan stated it informed the surveyors while they were on-site that a new treatment plan template had been developed that required the behavioral health clinicians to enter the return appointment frequency. Although the treatment plan template was continuing to evolve during the survey, the Plan stated it did not communicate or suggest that treatment plan audits had not already taken place.

The Plan stated it explained during the survey that results of the treatment plan audits were still being analyzed internally and that the Plan would be able to share the results of the audits statewide after the on-site portion of the survey had concluded. During the post survey discussion, the Plan explained that the treatment plan audits revealed over 90% compliance with treatment plan indicators, statewide.

The treatment plan audit time frame and number of cases reviewed

The Plan respectfully disagreed with the Department’s assertion that the treatment plan audit timeframe was too short and the number of cases reviewed was too small to be fully confident that the Plan is consistently compliant with follow-up appointment timeliness. The Plan responded that its audit universe consisted of 2,964 cases from January 1, 2016 to June 15, 2016. Of the 2,964 cases, 1,088 cases were reviewed to see if the documented return interval (return appointment) was consistent with the treatment plan, for individual therapy only. Of those cases that had return intervals documented, the statewide results demonstrated 88% compliance.

Treatment plan audit results were incorporated in the new treatment plan template

The Plan also took issue with the Department's finding that it was unclear whether the Plan incorporated the results of these treatment plan audits into oversight conducted by the Plan's access and quality assurance committees or if the Plan used the audit results to implement corrective actions where appropriate. In its response, the Plan affirmed that it shared the treatment plan audit results with the medical group operational leaders and used the findings as it refined the treatment plan template. For example, the Plan explained that not all treatment plans in the audit contained the clinicians' requested timeframe for each enrollee's follow up visit. As a result, the revised treatment plan template screen contains a "hard stop" that requires the clinician to insert the follow-up appointment timeframe. The follow-up appointment timeframe must be inserted into the template in order to move to the next page/screen of the treatment plan. The treatment plan templates were implemented in November 2015 in Southern California and May 2016 in Northern California. Since the implementation of these treatment plan templates, the Plan stated that subsequent chart audits have demonstrated an improved adherence to documentation of the required components into the treatment plans by the behavioral health clinicians.

The Plan also responded that treatment plan audit results were reviewed with the Regional Quality Vice Presidents of both regions and by the end of the first quarter of 2017, and that the treatment plan audit results would be reported up to the Behavioral Health Quality Oversight Committee, a subcommittee of the Regional Quality Committee in Northern California and reported up to the Behavioral Health Council, which is a subcommittee of the Southern California Quality Committee.

In conclusion, with regard to this portion of the deficiency, the Plan stated that a corrective action plan is not warranted. The Plan asserted that treatment plan audits were in place since January 1, 2016, the universe and sample size of its audits were sufficient, and the results of its internal audit found a statewide compliance rate of over 90% with treatment plan indicators. The Plan therefore requested removal of this deficiency.

Final Report Deficiency Status: Not Corrected

The Department recognizes that the Plan has undertaken substantial actions to correct access to behavioral health follow-up appointments by creating and implementing a treatment plan template and an audit process that tracks the availability and timeliness of follow-up appointments. The Department also finds the Plan's audit tool has been utilized by plan Committees for the purpose of improving enrollee access. The Department further finds the Plan has undertaken actions to improve short and long term access to mental health appointment availability. However, although the Plan has undertaken extensive and meaningful efforts to resolve the issues raised by this deficiency, the Plan has not provided the Department with long term, verifiable results demonstrating compliance. Thus, the Plan has not provided the Department with evidence demonstrating it has been consistently compliant in providing enrollees with access to appointments.

As described in the Deficiency Background, the Department's Follow-Up Report in February 2015 summarizes the history of the Department's concerns regarding enrollees obtaining access to follow-up behavioral health appointments. The

uncorrected access issues noted in that report were referred to the Department's Office of Enforcement for appropriate action in 2015. While the substance of the Plan's actions in that Enforcement matter remain confidential, as noted in the Plan's response, the Plan has been working with the Department's Office of Enforcement to correct these access deficiencies. However, the access issues remain unresolved.

Since the Department has identified access issues in this Routine Survey, and the Plan is already in the process of resolving these deficiencies with the Department's Office of Enforcement, this deficiency will be referred to the Department's Office of Enforcement. In addition, the Department will conduct a Follow-Up Survey within 18 months from the date the final report is issued to the Plan to determine and report on the status of the Plan's efforts to correct this deficiency.

Based upon the corrective actions undertaken by the Plan, and in light of the pending matter in the Department's Office of Enforcement, which is currently addressing resolution of the ongoing issues contained in this deficiency, the Department has determined that this deficiency has not been fully corrected.

GRIEVANCES AND APPEALS Southern and Northern California – Full Service and Behavioral Health

Deficiency #3: **The Plan does not immediately notify enrollees filing expedited grievances of their right to notify the Department of their grievance.**

Statutory/Regulatory Reference(s): Section 1368.01(b); Rule 1300.68.01(a).

Assessment: The Department's review of expedited grievance files found that the Plan did not consistently inform enrollees of their right to notify the Department of the expedited grievance.

Section 1368.01(b) states: "When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of the grievance." Rule 1300.68.01(a) supports the statutory requirement. The Department allows the Plan to demonstrate compliance by documenting immediate notification of the enrollee by telephone.

Plan Policy *Grievance Urgent Process and Resolution of Commercial Health Plan Member Issues*, confirms the statutory and regulatory requirements, stating that the Plan notifies the complainant verbally within 24 hours of his/her right to contact the Department regarding the urgent grievance.

File review findings in each region are discussed below.

Southern California Region

The Department received 70 grievance files for review. Of the 70 files, the Department found that two⁹ grievances were withdrawn by the enrollees, thus eliminating them from the review. Of the remaining 68 files, 56 did not meet the criteria for expedited review and therefore were processed as standard grievances. Of the 12¹⁰ files that met the criteria for expedited review, nine¹¹ files contained evidence that the enrollee was notified by telephone of their right to contact the Department regarding the expedited grievance. However, three¹² (25%) files lacked documentation that Plan informed the enrollee of their right to contact the Department.

TABLE 3
Southern California - Immediate Notification to the Enrollee of the Right to Contact the Department for Expedited Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance	12	Immediate notification to the enrollee of the right to contact the Department.	9 (75%)	3 (25%)

During interviews, Plan staff confirmed that the Plan's Policy *Grievance Urgent Process and Resolution of Commercial Health Plan Member Issues* directs staff to immediately inform enrollees of their right to contact the Department about an expedited grievance. The Plan acknowledged the lack of documentation in the reviewed cases.

Northern California Region

The Department received 69 grievance files for review. Of the 69 files, 31 did not meet the criteria for expedited review and therefore were processed as standard grievances. The Department reviewed 38 files as expedited grievances. Of the 38 files that met the criteria for expedited review, 20 (53%) files contained evidence that the enrollee had been immediately informed of their right to contact the Department regarding the expedited grievance. However, 18¹³ (47%) of the 38 expedited grievance files lacked documentation that the enrollee had been informed of their right to contact the Department.

During interviews, Plan staff stated that it was policy to inform enrollees immediately of their right to contact the Department about the grievance. However, during the Survey, the Department reviewed several of the non-compliant files with Plan staff who acknowledged that while there was a notation of "Verbal Ack," in some of the files, it was unclear to the Department and to Plan staff what information was relayed to the

⁹ File #12, File #22.

¹⁰ File #1, File #3, File #6, File #13, File #18, File #24, File #27.

¹¹ File #6, File #13, File #18, File #24, File #27.

¹² File #1, File #3, File #51.

¹³ File #1, File #3, File #12, File #13, File #14, File #19, File #21, File #23, File #27, File #28, File #34, File #37, File #38, File #39, File #42, File #54, File #56, File #57.

complainant who received verbal acknowledgement. In the 20 compliant case files, there was clear written documentation that the verbal acknowledgement included notification to the complainants of their right to contact the Department.

TABLE 4
Northern California - Enrollee Immediate Notifications of Right to Contact Department for Expedited Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance	38	Immediate notification to the enrollee of the right to contact the Department.	20 (53%)	18 (47%)

Conclusion: Section 1368.01(b) requires the plan to immediately notify enrollees of their right to contact the Department upon the plan’s receipt of a grievance for a case requiring expedited review. Rule 1368.01(b) supports the statutory requirement. In a review of expedited grievance files, the Department found that the Plan failed to consistently notify the enrollees of their right to contact the Department regarding the grievance. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan stated in its response to the Preliminary Report that it reviewed the files identified by the Department and stated that a performance improvement opportunity exists. The Plan identified this opportunity prior to the Department’s survey by way of internal auditing and the Plan began working on implementation of a CAP starting in December 2015.

The Plan stated its’s CAP includes, but is not limited to the following actions:

- i.
- ii. A mandatory in-service was held with Expedited Review Unit staff on 12/16/15, which included reinforcing the importance of immediately notifying members filing expedited grievances of their right to notify the DMHC of their grievance.
- iii. The verbal acknowledgement scripts utilized by Expedited Review Unit staff were updated on 2/9/16, following which appropriate training was provided. The scripts were updated to ensure staff consistently inform members of the right to notify the DMHC of their grievance and establish standard documentation guidelines of this notification in all expedited

grievance files.

- iv. Refresher training regarding verbal acknowledgement requirements, including immediately notifying members filing expedited grievances of their right to notify the DMHC of their grievance, was performed for Expedited Review Unit staff the weeks of 1/16/17 and 1/23/17.
- v. Review & discussion of the Preliminary Report deficiencies was held with Expedited Review Unit staff on 1/30/17.

As a result of these activities, the Plan stated that it has improved compliance with the requirements set forth in Sections 1368.01(b) and 1368(a)(5) and Rules 1300.68.01(a) and 1300.68(d)(4).

Final Report Deficiency Status: Not Corrected

The Department acknowledges that the Plan has taken steps towards correction of this deficiency through mandatory in-service training with the Expedited Review Unit staff, verbal acknowledgement script updates augmented by staff training, a staff refresher training of the member's right to immediately notify the Department and discussion with expedited review staff of the preliminary report deficiencies. However, the Department will need to review evidence, obtained through file review, of the implementation and effectiveness of the Plan's updated processes. At the time of the Follow-Up Survey the Department will conduct a file review of the Plan's expedited grievances to validate enrollees are being notified of the right to contact the Department.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

Deficiency #4: **For expedited grievance decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guideline used by the Plan and the clinical reasons for the decision.**

Statutory/Regulatory Reference(s): Section 1368(a)(5); Rule 1300.68(d)(4).

Assessment: The Department's review of expedited grievance files found that the Plan failed to consistently include a description of the criteria or guidelines used and the clinical reasons for the Plan's decision.

Rule 1300.68(d)(4) states that "The plan shall respond to grievances as follows:
(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response

shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination....”

The Department reviewed 69 files identified by the Plan as expedited grievances from the Plan’s Northern Region. Upon evaluation of the files, the surveyor determined that only 38 were processed by the Plan as expedited grievances. Of these 38 files, 20 involved adverse medical necessity determinations. Of these 20 files, 15 (75%) files included a description of the criteria, clinical guideline, or medical policy used in reaching the determination. The remaining five¹⁴ cases (25%) did not contain a description of the criteria, clinical guidelines or medical policies relied upon as the basis for the Plan’s denial. The following are examples:

- File #2: The enrollee states she has extreme pain in her back (ranging from 6-8 on a scale of 1-10), and requested her doctor to do more to identify the problem. When she requested an MRI, the doctor refused because she was not ready for surgery. He also lowered her dose of Tramadol, and she requested to go back to the dosage originally prescribed. The Plan’s expedited grievance response letter states:
... you requested the following:
 - an MRI
 - continued prescriptions for Tramadol at your previous dosing levels... we are denying your request. We do want you to understand why we came to this decision and have explained it below...
we denied these requests because an MRI and continued prescriptions for tramadol at your previous dosing levels are not medically indicated at this time. Our Committee determined that you have been offered the appropriate treatment for your diagnosis to this point and recommend that you follow-up with your primary care provider to discuss your concerns regarding the current treatment plan.

The letter does not include a description of the criteria, clinical guidelines or medical policies relied upon by the Plan when reaching its determination that the requested service was not medically necessary.

- File #57: This enrollee requested a refill of his Norco prescription, which the Plan denied "because it is not medically indicated at this time for you to be provided prescription medication refill for Norco. Our Physician Reviewer recommends you should be re-evaluated for your severe pain to determine the appropriate course of treatment for you."

The Plan’s letter does not provide any criteria, clinical guidelines or medical policies relied upon by the Plan when reaching its determination that the requested service was not medically necessary.

¹⁴ File #2, File #27, File #36, File #56, File #57.

TABLE 5
Expedited Grievance File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance (Northern Region)	20	The Plan provides a description of the criteria, clinical guidelines or medical policies relied upon when reaching its determination that the requested service was not medically necessary.	15 (75%)	5 (25%)

Conclusion: When the Plan denies requested services contained in a grievance, section 1368(a)(5) and rule 1300.68(d)(4) require the plan’s response to describe the criteria and the clinical reasons for its decision, including any related to medical necessity. The Department’s review of the Plan’s expedited grievance response letters found that the Plan’s letters did not consistently contain the criteria, clinical guidelines and/or medical policies relied upon when reaching its determination to deny services. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan’s Compliance Effort:

The Plan responded to the Department that it reviewed the five files identified by the Department and agreed that a performance opportunity exists. The Plan stated it identified this improvement opportunity during an internal audit and commenced work on a CAP beginning in December 2015.

The Plan’s CAP includes:

- i. Quality/Service Message memos regarding requirements for denial rationale language were sent by management to Member Service staff and Expedited Review Unit staff in 2015.
- ii. An in-service was held with Expedited Review Unit staff on 12/16/15, which included reinforcement of the denial rationale requirements that were distributed in the Q2’15 Letter Quality Messages for including the appropriate criteria or guideline used by the plan and the clinical reasons for the decision in medical necessity denial letters.
- iii. Expedited Review Unit Statewide Refresher training specific to

Resolution letter requirements (including medical necessity denial rationales) was provided in June 2016.

- iv. On 6/21/16, Expedited Review Unit Refresher Training was conducted, which included reinforcement of denial letter requirements and providing specific reasons for the denial in written notices.
- v. Training of Expedited Review Unit staff was provided on 7/25/16 using a “Go Animate” video regarding requirements for denial rationale language.
- vi. In August 2016, an in-service was held with Expedited Review Unit physician reviewers to reinforce the requirements for complete documentation of the denial decision rationale/criteria/guidelines relied upon in making the denial decision, to ensure that Expedited Review Unit representatives have the necessary criteria or guideline information used by the plan and the clinical reason(s) for the decision so that it may be included in the written response to the member.
- vii. Review & discussion of the Preliminary Report deficiencies was held with Expedited Review Unit staff on 1/30/17.
- viii. Refresher training regarding decision rationale requirements was performed for Expedited Review Unit staff the weeks of 1/24/17 and 1/30/17.

Final Report Deficiency Status: Not Corrected

The Department acknowledges that the Plan has provided memos and training for its Expedited Review Unit staff and physicians. However, the Department will need to review evidence of the effectiveness of the Plan’s refresher/physician in-service training through file review. At the time of the Follow-Up Survey, the Department will conduct a file review of the Plan’s expedited grievances to validate compliance with requirement to provide a description of the criteria or guideline used by the plan and the clinical reasons for the decision.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

UTILIZATION MANAGEMENT Southern and Northern California – Full Service and Behavioral Health

Southern and Northern California Regions

Deficiency #5: The Plan does not consistently consider the “reasonable person” standard when evaluating the medical necessity of emergency services.

Statutory/Regulatory Reference(s): Section 1371.4(a)-(c); Rule 1300.67.2(c).

Assessment: In a review of emergency claims denial files from the Southern and Northern California regions, the Department found that the Plan inappropriately denied payment for emergency services and care when the enrollees were out of the Plan's network because it did not adequately consider the "reasonable person" standard in its own policy. For an enrollee to experience an emergency, California's Health and Safety Code Sections 1317.1 and 1371.4(c) contemplate that an emergency medical condition exists from the enrollee's subjective viewpoint, which is referred to as the "reasonable person" standard.¹⁵ Thus, the reasonable person standard states that an emergency exists when a reasonable person would have believed that the absence of immediate medical attention would result in serious jeopardy, serious bodily impairment, and/or serious dysfunction of an organ or part.

Section 1371.4(c) states that "a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care *and the enrollee reasonably should have known that an emergency did not exist* [emphasis added]. Rule 1300.67.2(c) requires that "[e]mergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week."

The Plan's enrollee materials support the requirements of Section 1371.4(a) – (c) and Rule 1300.67.2(c). The Plan's *2015 Individual Plan Membership Agreement and Evidence of Coverage for Kaiser Permanente for Individuals and Families* describes the conditions under which enrollees may seek emergency services, as follows:

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world if the Services would have been covered under the "Benefits and Your Cost Share" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

The Plan's EOC document for large group clients, *The Kaiser Permanente Deductible HMO Plan, Evidence of Coverage for Sample Group Agreement* defines emergency services as follows:

¹⁵ In contrast, federal law provides the "prudent layperson standard" which is a different definition for an emergency medical condition. The prudent layperson standard defines an emergency medical condition as a condition that manifests itself by acute symptoms of sufficient severity such that a prudent layperson would experience provided they possesses an average knowledge of health and medicine. Application of the prudent layperson standard is generally provides more restrictive coverage than the reasonable person standard.

Emergency Services: All of the following with respect to an Emergency Medical Condition:

A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition

The Plan's Southern California policy, *Emergency Prospective Review Program*, cites the reasonable person standard when defining emergency medical condition as follows:

4.4.1 Emergency Medical Condition:

- 4.1.1 A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a *reasonable person* [emphasis added] would have believed that the absence of immediate medical attention would result in any of the following:
 - 4.1.1.1 Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
 - 4.1.1.2 Serious bodily impairment
 - 4.1.1.3 Serious dysfunction of any bodily organ or part

File Review

The Department reviewed emergency room (ER) denial files from the Plan's Southern and Northern California regions. File review findings from each region are discussed below:

Southern California

The Department initially reviewed the first 32 files (Batch 1) of the 82 ER denial files provided by the Plan. The Department found that all 32 denial files were denied for administrative reasons, e.g., lack of eligibility. As a result of this finding, the Department asked the Plan to submit a new file sample (Batch 2) of 12 ER denial files reflecting the denial reason codes "non-emergent" and "not authorized." Of these 12 files, 11 denials reflected the reason code, non-emergent, and one denial file reflected the reason code, not authorized. One of the files (File #9) was paid and thus eliminated from the review. The Department's review of the 11 ER denials identified three¹⁶ (27%) files for which the Plan inappropriately denied payment of emergency services because it did not consider the "reasonable person" standard when evaluating the medical necessity of the emergency services. The following files are examples of this deficiency:

- **File #3:** A 38-year-old enrollee presented to the ER with severe toothache. According to the ER medical record, the enrollee had "severe toothache, characterizing the pain as 10 on a scale of 1 to 10, radiating into his cheeks and face," requiring "an intramuscular injection of Ketorolac for relief of pain."

¹⁶ File #3, File #6, and File #7.

Although it is reasonable for the enrollee to have expected continued severe pain without medical care, the Plan's denial letter failed to explain how the enrollee's condition failed to meet the reasonable person standard as described in the Plan Policy, *Emergency Prospective Review Program*.

- File #6: This enrollee presented to the ER for "testicular pain, swelling" and "trickling" when urinating. The ER notes the enrollee's need for pain medication and the need to be off work for a week. However, the Plan denied coverage for the services on the basis that the enrollee received services while outside of the Plan's service area, and that the enrollee's pain was expected. The Plan's response did not discuss the reasonable person standard as it related to the enrollee's medical emergency.

Northern California

The Department reviewed 20 ER claim denial files and found that in 9¹⁷ (45%) files, the Plan did not consistently consider the reasonable person standard when evaluating the medical necessity of emergency services. The following are examples of this deficiency:

- File #3: This enrollee was 15 weeks pregnant and presented twice in the emergency room, three days apart, for pain. However, the Plan denied the second ER visit without considering the reasonable person standard as defined in the Plan Policy, *Emergency Prospective Review Program*.
- File #6: This enrollee was approximately six months pregnant and presented to the ER with right groin pain, low back pain, and dizziness when standing. In the ER, the enrollee continued to have low blood pressure despite receiving intravenous fluids. The ER physician consulted with an obstetrician who recommended placing the enrollee under observation. However, the Plan physician reviewer documented the rationale for the denial on the basis that the enrollee was outside of the Plan's service area and that there was no true emergency. The Plan did not discuss its reasonable person standard.

¹⁷ File #2, File #3, File #4, File #6, File #7, File #9, File #11, File #13, File #15.

TABLE 6
Emergency Denial File Review for Reasonable Person Standard

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
ER Denial Files (Southern Region)	11	Plan considered the “reasonable person” standard when evaluating the medical necessity of emergency services.	8 (73%)	3 (27%)
ER Denial Files (Northern Region)	20	Plan considered the “reasonable person” standard when evaluating the medical necessity of emergency services	11 (55%)	9 (45%)

Conclusion: Section 1371.4(c) allows the Plan to deny reimbursement to providers in cases where the enrollee did not require emergency services and care, and the enrollee reasonably should have known that an emergency did not exist. Rule 1300.67.2(c) requires that emergency services must be available and accessible within the service area twenty-four hours a day, seven days a week. In a review of ER denial files for the Southern and Northern regions, the Department found that the Plan did not consistently apply the “reasonable person” standard to its denials of payment for emergency services when enrollees were out of the Plan’s network. Therefore, the Department finds the Plan in violation of these statutory and regulatory requirements.

Notably, the Plan was cited for a similar deficiency in a 2006 Non-Routine Medical Survey.¹⁸ The Department assessed an administrative penalty of \$500,000 against the Plan, of which \$250,000 was suspended, and later reinstated, upon the Plan’s failure to meet the goals enumerated in the Agreement.¹⁹

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan’s Compliance Effort: In its response to the Preliminary Report the Plan reiterated its longstanding policy that no out of-plan emergency room claims are to be denied by applying a standard not compliant with the Knox-Keene Act. The Plan stated it processes over a half million out-of-area emergency claims each year. Out of all of all of those claims, only a very few number of files were identified as denied based

¹⁸ [Final Report](#) Non-Routine Medical Survey of Kaiser Foundation Health Plan, Inc.; see deficiency #6.

¹⁹ DMHC Enforcement Matter No. 05-326, [Letter of Agreement](#) dated April 2, 2007 and [Letter of Agreement](#) dated October 15, 2008.

on failure to meet the reasonable person standard. When the Plan discovered these errors before the survey, it immediately paid these claims.

In order to address the deficiency the Plan initiated training on January 31, 2017 to ensure that reviewers who erroneously denied claims fully understand the Plan's longstanding policy.

Final Report Deficiency Status: Not Corrected

Department review of the Plan's training: *Clinical Review of Claims for Services without Authorization* and the Plan's attendance roster for training confirmed that the Plan has implemented a process to ensure that out of plan emergency services will be appropriately covered. The Plan confirmed that it will apply the correct review standard for emergency room claims as required by the Knox-Keene Act. However, the Department notes the Plan continues to use the terminology "prudent layperson" rather than "reasonable person" in its documentation provided in its response to the preliminary report. Correct terminology is important since, as noted above, the prudent layperson standard is a more restrictive standard in its application since it allows the plan to consider whether the enrollee had average knowledge of health and medicine when experiencing an emergency. In contrast, the reasonable person standard contemplates the enrollee's subjective viewpoint to determine whether the enrollee experienced an emergency medical condition.

Within 60 days, the Plan shall submit a supplemental response which identifies the Plan's progress in implementing "reasonable person" in its training, processes, etc. Additionally, at the time of the Follow-Up Survey the Department will need to review evidence that the Plan's corrective actions have effectively corrected the deficiency. Such evidence may include additional file review and/or the results of any internal plan audits demonstrating the Plan's compliance with its policies and procedures regarding the processing of emergency claims.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

Deficiency #6: **For decisions to deny emergency services based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guidelines used, and the clinical reasons for the decision.**

Statutory/Regulatory Reference(s): Section 1367.01(h)(4).

Assessment: In a review of ER denial files, the Department found that for decisions to deny emergency service based in whole or in part on medical necessity, the Plan did not consistently include in its written response a description of the criteria or guidelines used and the clinical reasons for the decision.

Section 1367.01(h)(4) requires that “[c]ommunications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall ... include ... a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.”

The Plan’s policies and procedures: Plan Policy, *Emergency Prospective Review Program*, supports this statutory requirement.

File Review

The Department reviewed ER denials files from both the Southern and Northern California regions. The following details the Department’s findings from each region.

Southern California

The Department reviewed the same 11²⁰ ER claim denials in deficiency #5 and found that in 3²¹ (27%) files, the Plan’s denial letters failed to include a description of the criteria or guidelines used and the clinical reasons for the decisions regarding medical necessity.

- **File #3:** This 38-year-old enrollee presented to the ER with severe toothache. The Plan’s denial letter to the enrollee states:

Your records reflect that the patient went out of Plan for prescheduled care. This type of care must be received at a Plan designated facility or authorized by us. Your benefits for unauthorized care are limited to care needed to treat an emergency medical condition or, if you are temporarily out of the service area, Urgent Care for an unforeseen illness or injury, as those conditions are described in the “Emergency Services and Urgent Care” section of the Evidence of Coverage. If enrolled in the Federal Health benefits Program, please refer to section 5 “emergency services/accidents,” of the federal brochure. We will be happy to provide a copy of the scientific or clinical standards as well as any internal rule, guideline, or protocol that applies to the patient's circumstances, without charge, if requested. You are responsible for payment of this denied charge.

The Plan’s denial letter did not include a description of the criteria or guidelines used by the Plan to reach this decision or the clinical reasons for the Plan’s decision.

- **File #6:** This enrollee presented to the ER for “testicular pain, swelling” and “trickling” when urinating. The Plan’s denial letter states:

Our review indicates that the patient's unauthorized care was not for an emergency medical condition and in fact the patient's symptoms were not unexpected and/or the patient was permanently outside our service area. If enrolled in the federal employees ... please refer to section 5 ... ‘emergency services/accidents,’ of the federal brochure. We will be happy to provide a

²⁰ One File #9, of the 12 files was approved for payment; thus eliminated from the review.

²¹ File #3, File #6, and File #7.

copy of the scientific or clinical standards as well as the internal rule, guideline, or protocol that apply to the patient's circumstances, without charge, if requested. You are responsible for payment of this denied charge.

The Plan's denial letter did not include a description of the criteria or guidelines used by the Plan to reach this decision or the clinical reasons for the Plan's decision.

Northern California

The Department reviewed the same 20 ER claim denial files cited in deficiency #5 and found that in 11²² (55%) files the Plan did not consistently include a description of the criteria or guidelines used and the clinical reasons for the decisions regarding medical necessity.

- File #3: This enrollee was 15 weeks pregnant and presented twice in the emergency room, three days apart, for pain. The Plan's denial letter states in relevant part:

Your records reflect that you went out of the plan for follow up care for a stable, improving or persistent condition. Follow up care is considered routine. Routine care must be obtained at a Plan facility. Please refer to the "Preventive Care Services: Outpatient Care" sections of the patient's Evidence of Coverage for more coverage details. We will be happy to provide a copy of the scientific or clinical standards as well as any internal rule, guideline, or protocol that applies to the patient's circumstances, without charge, if requested. You may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion, as applicable, on which the denial decision was based, upon request, by calling [Listed Phone Number].

Emergency Care If you have an emergency medical condition, call 911 or go to the nearest hospital. An emergency medical condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor wherein there isn't enough time for safe transfer to a Plan hospital (or designated hospital).

The Plan's denial letter did not include a description of the criteria or guidelines used by the Plan to reach this decision or the clinical reasons for the Plan's decision.

- File #4: The enrollee went to the ER twice in three days for low back pain radiating to the hips, characterized as sharp. During the first visit to the ER, the enrollee was treated with the pain medications, Motrin and Norco. During the second visit to the ER, the enrollee was given a tranquilizer (Valium) and stronger pain medications (Dilaudid and Toradol) in addition to more Norco. The Plan's denial letter states in relevant part:

²² File #3, File #4, File #5, File #6, File #7, File #8, File #9, File #11, File #13, File #15, File #19.

...claim has been denied for the reasons below: Your records reflect that you have gone out of Plan multiple times for care related to similar complaints. Your provider will be informed of this. We encourage you to contact your practitioner to discuss the best way to manage this apparently persistent health care needs. Please note that any claims for non-authorized care you receive outside the KP network will be reviewed by HP Clinical Review. Charges for care that is not treatment of an emergency medical condition or out of area Urgent Care will not be covered. Please refer to the "Emergency Services and Urgent Care" section of the patient Evidence of Coverage for more coverage details. For Federal Employees..., please refer to section 5 "emergency services/accidents," of the federal brochure. We will be happy to provide a copy of the scientific or clinical standards as well as any internal rule, guideline, or protocol that applies to the patient's circumstances, without charge, if requested."

The Plan's denial letter did not include a description of the criteria or guidelines used by the Plan to reach this decision or the clinical reasons for the Plan's decision.

- File #6: This case involves a 24-year-old enrollee who was approximately six months pregnant who presented to the ER with right groin pain, low back pain, and dizziness when standing. The ER physician consulted with an obstetrician who recommended placing the enrollee under observation. The Plan's denial states:

Your records reflect that you went out of Plan for prescheduled care. This type of care must be received at a Plan designated facility or authorized by us. Your benefits for unauthorized care are limited to care needed to treat an emergency medical condition or, if you are temporarily out of the service area, Urgent Care for an unforeseen illness or injury. Please refer to the Preventive Care services: outpatient care sections of the patient's Evidence of Coverage for more coverage details. We will be happy to provide a copy of the scientific or clinical standards as well as any internal rule, guideline, or protocol that applies to the patient's circumstances, without charge, if requested.

The letter proceeded to define emergency care:

Emergency Care If you have an emergency medical condition, call 911 or go to the nearest hospital. An emergency medical condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor wherein there isn't enough time for safe transfer to a Plan hospital (or designated hospital) before delivery, or if transfer poses a threat to your (or unborn child's) health and safety."

The Plan's denial letter did not include a description of the criteria or guidelines used by the Plan to reach this decision or the clinical reasons for the Plan's decision.

TABLE 7
Emergency Denial File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
ER Denial Files (Southern Region)	11	Denial letter described the criteria, and provided clinical reasons for the decision	8 (73%)	3 (27%)
ER Denial Files (Northern Region)	20	Denial letter described the criteria, and provided clinical reasons for the decision	9 (45%)	11 (55%)

Conclusion: Section 1367.01(h)(4) requires that the Plan’s written communications to enrollees regarding decisions to deny, delay, or modify requested health care services include a description of the criteria or guidelines used, and the clinical reasons for the decisions. As a result of a file review for both the Southern and Northern regions involving denials of emergency services and care to enrollees, the Department determined that the Plan consistently denied these services without providing descriptions of the criteria or guidelines used, and the clinical reasons for the decisions. Therefore, the Department finds the Plan in violation of this statutory requirement.

Corrective Action: Within 45 days following notice of this deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that had been taken to correct the deficiency.

Plan’s Compliance Effort: In its February 1, 2017 response to deficiency #6 the Plan stated:

The Plan’s policy is that it does not deny out-of-plan ER claims based on failure to satisfy the PLP standard, and as such the Plan has no need to describe criteria or guidelines used, or the clinical reasons for the decision. The Plan reiterates that the claims identified in deficiency #5, were the result of reviewers not following the Plan’s policy.

Final Report Deficiency Status: Not Corrected

As noted in the Plan’s response to deficiency #5, the Plan confirmed that going forward, it will apply the correct review standard for emergency room claims as required by the Knox-Keene Act. The Plan stated it had implemented a process, including training the reviewers who erroneously denied these emergency claims, to ensure that out of plan emergency services will be appropriately covered. At the Follow-Up Survey, the Department will need to review evidence, through file review, demonstrating the effectiveness of the Plan’s corrective actions.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. Where indicated, the Plan shall submit a supplemental 60-day response through the Department's Web portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrective actions.

Any amendments and modifications made to the Plan's licensing documents as a result of this Routine Survey must be submitted to the Department via the web portal using the "File Documents" link. The Plan should indicate in its Exhibit E-1 Summary of eFiling Information that this policy is being filed as a result of a deficiency identified by the Division of Plan Surveys.

The Department will conduct a Follow-Up Review of the Plan and issue a Report within 14-16 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, [DMHC Web Portal](#).

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link.
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled, **2016 Routine Full Service Survey - Document Request**.
- Submit the response to the Final Report via the "DMHC Communication" tab.

[Plan Response to the Final Report](#)