DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

ROUTINE SURVEY

OF

KAISER FOUNDTION HEALTH PLAN, INC.

DBA: KAISER PERMANENTE

A FULL SERVICE HEALTH PLAN

DATE OF FOLLOW-UP REPORT:
JANUARY 30, 2019

Routine Survey Follow-Up Report
Kaiser Foundation Health Plan, Inc.
DBA Kaiser Permanente
A Full Service Health Plan
January 30, 2019

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EXECUTIVE SUMMARY

In the Final Report for the Routine Survey (Final Report),[1] dated June 12, 2017, the Department of Managed Health Care (Department) identified six uncorrected deficiencies. Kaiser Foundation Health Plan, Inc. (Plan) was advised that the Department would conduct a follow-up review (Follow-Up Survey) to assess the status of the six uncorrected deficiencies and issue a report within 18 months of the date of the Final Report.

On July 18, 2017, the Department entered into a Settlement Agreement with the Plan in Enforcement Matter 15-082 (Settlement Agreement). The Settlement Agreement addressed Deficiency #2 of the Final Report. In Deficiency #2, the Department found that the Plan's Quality Assurance (QA) Program failed to ensure effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care. Deficiency #2 was also a repeat deficiency from the Follow-Up Survey Report issued in February 2015. The complete Settlement Agreement is located on the Department's public website.[2]

On February 13, 2018, the Department notified the Plan that the Follow-Up Survey had commenced, and requested the Plan submit information regarding its uncorrected deficiencies as cited in the Final Report.

The survey team conducted the Follow-Up Survey pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), codified at Health and Safety Code section 1340 *et seq*., and Title 28 of the California Code of Regulations section 1000 *et seq*.[3]

The Follow-Up Survey addressed outstanding deficiencies in the following areas:

- Quality Assurance
- Quality Assurance and Availability of Services
- Grievances and Appeals
- Utilization Management

The Follow-Up Survey determined two of the previous six outstanding deficiencies are pending further review, one has not been corrected and three have been corrected.

[1] The Kaiser 2016 Routine Survey Final Report can be accessed on the DMHC public website.
[2] The Kaiser 2017 Settlement Agreement can be accessed on the DMHC public website.
[3] All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON JUNE 12, 2017	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	QUALITY ASSURANCE 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).	**Pending**
	QUALITY ASSURANCE AND AVAILABILITY OF SERVICES Southern and Northern California-Behavioral Health	
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. 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).	**Pending**
	GRIEVANCES AND APPEALS Southern and Northern California-Full Service and Behavioral Health	
3	**The Plan does not immediately notify enrollees filing expedited grievances of their right to notify the Department of their grievance.** Section 1368.01(b); Rule 1300.68.01(a).	**Corrected**
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.** Section 1368(a)(5); Rule 1300.68(d)(4).	**Not Corrected**

	UTILIZATION MANAGEMENT Southern and Northern California-Full Service and Behavioral Health	
5	**The Plan does not consistently consider the "reasonable person" standard when evaluating the medical necessity of emergency services.** Section 1371.4(a)-(c); Rule 1300.67.2(c).	**Corrected**
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.** Section 1367.01(h)(4).	**Corrected**

SECTION I: SUMMARY OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT AND FOLLOW-UP SURVEY FINDINGS

The following details the Department's findings regarding the outstanding deficiencies. The Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health and Safety Code section 1380(i).

QUALITY ASSURANCE Southern California-Behavioral Health

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).

Plan's Follow-Up Compliance Effort: On July 18, 2017, the Plan entered into a Settlement Agreement with the Department. By entering into the Settlement Agreement, the Plan agreed to improve its Behavioral Health QA program and to ensure that effective action is taken to improve care where deficiencies are identified, including accessibility, availability, and continuity of care. The Settlement Agreement requires the Plan engage the services of a consultant to assist and monitor the Plan's Behavioral Health QA program. The Plan and the consultant are required to work together in order to achieve the goals of the Settlement Agreement, which are detailed in the benchmarks described in paragraph 44. The Plan and consultant are required to focus on six specific "Corrective Action Areas," which are described in paragraph 40 and summarized below:

1. Improved documentation of the Plan's quality improvement efforts for access compliance;
2. Improved transparency in behavioral health appointment access compliance measurement;
3. Improved monitoring of member impact of access insufficiency and associated real time member remediation;
4. Fully implemented systematic process to monitor follow-up appointment access adherence to the enrollee's treatment plan;
5. Improved internal corrective action plan development; and
6. Improved integration of external provider access data and oversight.

Follow-Up Survey Assessment: To determine the status of the Plan's compliance efforts in its Follow-Up Survey, the Department assessed whether the Plan has undertaken corrective action pursuant to the terms of the Settlement Agreement. However, under the terms of the Settlement Agreement, the Plan's corrective actions are ongoing and being assessed by the consultant. Also, some of the benchmark timeframes described in paragraph 44 have not yet occurred. As a result, the Department has not made a complete assessment of the Plan's corrective actions in the Follow-Up Survey.

Nevertheless, the Department has determined that the Plan has undertaken appropriate efforts under the terms of the Settlement Agreement to begin correcting this deficiency. Thus far, the Plan has timely met the benchmarks provided in the Settlement Agreement. The Plan's corrective actions include the following:

- Development of yearly work plans with the designated expert consultant for the first two years of the consultation period.
- Improved timely access compliance measurement mechanism that delineates when appointments that do not meet timely access standards result from member choice or lack of availability.
- Implementation of improved/revised internal corrective action plan process.
- Implementation of improved monitoring and remediation activities related to impact of when enrollees are not offered a timely appointment.
- Implementation of follow-up appointment monitoring process regarding adherence to an enrollee's treatment plan.
- Implementation of improved data monitoring of external (contracted) network access.
- Updated QA documents, policies and procedures.

Follow-Up Report Deficiency Status: Pending

The Department determined that the Plan's corrective actions under the terms of the Settlement Agreement will serve as the basis for the correction of this deficiency by verifying whether the Plan's corrective action plans (CAP) were implemented and effective. While the Department finds that the Plan has implemented and met some of the requirements in the Settlement Agreement to date, the Plan's corrective actions are ongoing and some benchmark dates have not yet taken place. Given that the Plan's corrective actions are ongoing, the Department has determined that additional review is necessary to determine compliance. The Department will review the Plan's entire QA program during the 2019 Routine Survey and continue to monitor the Plan's compliance with the terms of the Settlement Agreement.

QUALITY ASSURANCE 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); Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3).

Plan's Follow-Up Compliance Effort: On July 18, 2017, the Plan entered into a Settlement Agreement with the Department. By entering into the Settlement Agreement, the Plan agreed to improve its Behavioral Health QA program and to ensure that effective action is taken to improve care where deficiencies are identified in service

areas, including accessibility, availability, and continuity of care. The Settlement Agreement requires the Plan to engage the services of a consultant to assist and monitor the Plan's Behavioral Health QA program. The Plan and the consultant are required to work together in order to achieve the goals of the Settlement Agreement, which are detailed in the benchmarks described in paragraph 44. The Plan and consultant are required to focus on six specific "Corrective Action Areas," which are described in paragraph 40 and summarized below:

1. Improved documentation of the Plan's quality improvement efforts for access compliance;
2. Improved transparency in behavioral health appointment access compliance measurement;
3. Improved monitoring of member impact of access insufficiency and associated real time member remediation;
4. Fully implemented systematic process to monitor follow-up appointment access adherence to the enrollee's treatment plan;
5. Improved internal corrective action plan development; and
6. Improved integration of external provider access data and oversight.

Follow-Up Survey Assessment: To determine the status of the Plan's compliance efforts in its Follow-Up Survey, the Department assessed whether the Plan has undertaken corrective actions pursuant to the terms of the Settlement Agreement. However, under the terms of the Settlement Agreement, the Plan's corrective actions are ongoing and being assessed by the consultant. Also, some of the benchmark timeframes described in paragraph 44 have not yet occurred. As a result, the Department has not made a complete assessment of the Plan's corrective actions in the Follow-Up Survey.

The Department has determined that the Plan has undertaken appropriate efforts under the terms of the Settlement Agreement to begin correcting this deficiency. To date, the Plan has timely met some of the benchmarks provided in the Settlement Agreement. The Plan's corrective actions include the following:

- Development of yearly work plans with the designated expert consultant for the first two years of the consultation period.
- Improved timely access compliance measurement mechanism that delineates when appointments that do not meet timely access standards result from member choice or lack of availability.
- Implementation of improved/revised internal corrective action plan process.
- Implementation of improved monitoring and remediation activities related to impact of when enrollees are not offered a timely appointment.
- Implementation of follow-up appointment monitoring process regarding adherence to an enrollee's treatment plan.
- Implementation of improved data monitoring of external (contracted) network access.
- Updated QA documents, policies and procedures.

Follow-Up Report Deficiency Status: Pending

The Department determined that the Plan's corrective actions under the terms of the Settlement Agreement will serve as the basis for the correction of this deficiency by verifying whether the Plan's action(s) have improved access to mental health appointment availability. The Department finds that the Plan's corrective actions are ongoing under the terms of the Settlement Agreement. To date, the Plan has met some of the requirements outlined in the Settlement Agreement to address this deficiency. Given that the Plan's corrective actions are ongoing, the Department has determined that additional review is necessary to determine compliance. The Department will review the Plan's entire QA program during the 2019 Routine Survey and continue to monitor the Plan's compliance with the terms of the Settlement Agreement.

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).

Plan's Follow-Up Compliance Effort: In addition to the corrective actions described in the Final Report, the Plan reported it has taken the following actions to address this deficiency:

- On July 19, 2017, the Plan re-trained the Expedited Review Unit (ERU) staff on the importance of immediately notifying enrollees filing expedited grievances of their right to notify the Department.

- On October 16, 2017, the Plan revised its expedited grievance policy, *Grievance and Urgent Process and Resolution of Commercial Members Policy and Procedure (Number 50-8)* (Expedited Grievance Policy).

Supporting Documentation:

- Expedited Grievance Policy, revised October 16, 2017
- Evidence of training sessions conducted on December 16, 2015
- Evidence of a Statewide ERU Team Meeting conducted January 30, 2017 and an ERU Staff Meeting held July 19, 2017
- Revised materials/scripts for handling expedited grievances which emphasized the enrollee's right to notify the Department
- The Plan's 2016 and 2017 internal audit results

Plan Internal Audits

The Plan provided internal audit results for 2016 and 2017 to demonstrate it has implemented an effective process to ensure immediate notification of its enrollees to notify the Department when filing an expedited grievance. The Plan explained that the results of these internal surveys are used to quickly identify issues, trends and training

needs for individual processors statewide. The results are reported to the Member Services Quality and Risk Committee on a quarterly basis.

Follow-Up Survey Assessment: To verify the Plan's reported compliance, the Department reviewed the Plan's documents. The Plan's revised Expedited Grievance Policy states that the Plan's policy is to provide verbal acknowledgement in response to expedited grievances within 24 hours of receipt. The Expedited Grievance Policy also states that acknowledgment of the timeliness is tracked by the Plan through the Complaint Integrated Workflow and Reporting System (CIWRS). The Policy provides that the Plan's documentation includes creating a complete, comprehensive, and accurate record within CIWRS ensuring that all information relevant to the enrollee's case is attached and complete for grievances, complaints and appeals. The Policy notes that all documentation must be entered into CIWRS as soon as possible, but no later than the end of the next business day.

The Plan also provided training documents which showed that training materials were developed to address these requirements when responding to expedited grievances. The documents demonstrate that Plan staff have been trained to provide verbal acknowledgment to enrollees within 24 hours of receipt of the request for an expedited grievance including notification of the enrollee's right to notify the Department.

In addition, the Plan's 2016-2017 Internal Audit results show that the Plan's internal audit of these acknowledgement timeframe requirements.

File Review

During the Follow-Up Survey, the Department reviewed 30 expedited grievance files for the review period of July 2017 through February 2018. The Department's review found that the Plan provided notification to enrollees of their right to directly contact the Department per the Plan's policies and procedures.

Follow-Up Report Deficiency Status: Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been 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).

Plan's Follow-Up Compliance Effort: In addition to the corrective actions described in the Final Report, the Plan reported it has taken the following actions to address this deficiency:

- On July 5, 2017, the Plan sent a 'Quick Tip' email to all California Member Services staff regarding the requirements for medical necessity denial rationale.
- On January 24, 2018, the Plan trained the ERU staff regarding decision rationale requirements.
- On February 28, 2018, the Plan reviewed the decision rationale requirements with the ERU physicians.

Supporting Documentation:

- *Language Requirements for Medical Necessity Denials Rationale*
- Evidence of multiple training sessions discussing the Writing Letter Highlights/California Member Services ERU
- Evidence of the Plan's February 28, 2018 training provided to physician reviewers, which discussed including medical rationale/elements for denied medical care/services in the Plan's denial letters
- *Letter Quality Messages*, which demonstrated that the Plan has implemented a process to ensure the Plan consistently cites in its written denial a description of the criteria, guidelines or medical policy used by the Plan

Plan Internal Audits

The Plan also provided its internal audit results for 2016 and 2017 to demonstrate it consistently includes in its written responses for expedited grievances a description of the criteria or guideline used by the Plan in addition to inclusion of the clinical reasons for the Plan's decision.

Follow-Up Survey Assessment: The Department reviewed the Plan's documents, which provided evidence that for expedited grievances, the Plan implemented a process and provided training to ensure it consistently cites in its written response a description of the criteria, guidelines or medical policy used to make its medical necessity denial. The Plan also submitted its quarterly internal audit results for 2016 and 2017 as evidence of the effectiveness of the Plan's process to include the clinical criteria and medical reasoning in its denial determinations.

File Review

During the Follow-Up Survey, the Department reviewed 65 expedited grievance files for the review period of July 2017 through February 2018. The Department's review found that the Plan failed to consistently include a description of the criteria or guideline used and the clinical reasons for the Plan's decision in 15[4] out of 65 (23%) of the files. The following letters exemplify the basis for finding this deficiency uncorrected:

[4] File #7, File #13, File #25, File #32, File #33, File #43, File #44, File #50, File #52, File #55, File #62, File #63, File #64, File #66, File #67.

- **File #13:** The enrollee requested surgery. The Plan's response states:

  We carefully reviewed your records and other relevant information to come to our decision and we are denying your request. We do want you to understand why we came to this decision and have explained it below.

  The Committee has reviewed your medical records information and determined that your request is not medically indicated at this time.

  If your pain level has increased to an intolerable level, it is recommended that you obtain a reevaluation in the Orthopedics Department.

  According to your 2017 Evidence of Coverage (EOC) for Kaiser Permanente Individuals and Families, under page 21 section titled, "Benefits and Your Cost Share", it states the following:

  We cover the Services described in this "Benefits and Your Cost Share" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:

  - The Services are Medically Necessary
  - The Services are provided, prescribed, authorized, or directed by a Plan Physician

  In consultation with the Physician Reviewer, the following individuals met as a committee to discuss and evaluate your request:

  - Associate Medical Director, Member Services, Internal Medicine

  This completes our response to your grievance through Kaiser Foundation Health Plan's internal grievance process.

The Plan's response letter does not include a description of the criteria, clinical guideline or medical policies that the Plan relied upon to determine that the requested service was not medically necessary. The letter's reference to the enrollee's Evidence of Coverage (EOC) is insufficient as a citation to a criteria, clinical guideline or medical policy. In addition, the letter does not contain any clinical reasons to support the Plan's decision.

- **File #33:** The enrollee requested aggressive x-rays and nutrition, physical therapy, holistic and homeopathic medicine. The Plan's response states:

  We carefully reviewed your records and other relevant information to come to our decision and we are denying your request. We do want you to understand why we came to this decision and have explained it below.

Physician Review of your request and relevant medical records determined that the requests are not medically indicated pending further evaluation. Physician Review recommends that you follow up with your primary care provider to establish an appropriate plan of care.

Please understand the denial is based on your agreement with Kaiser Permanente through CalPERS. The 2017 Kaiser Permanente Evidence of Coverage (EOC) states we cover medical services that are medically necessary (page 18). The EOC specifies that "A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community" (page 4)

If you would like a copy of the referenced EOC pages, at no charge, please contact me at [ ].

[ ] please know that we care about your health and we encourage you to follow up with Dr. [ ] of the [ ] Medical Center Family Medicine Department. Should you need assistance in scheduling an appointment that is most convenient for you, please call the appointment center at [ ].

The following individuals met as a committee to discuss and evaluate your request:

- MD, Kaiser Permanente Associate Medical Director, Member Services – Internal Medicine
- RN, Clinical Consultant, Expedited Review Unit (ERU)
- Team Manager, Expedited Review Unit (ERU)
- Senior Consultant, Expedited Review Unit (ERU)

This completes our response to your grievance through Kaiser Foundation Health Plan's internal grievance process.

This letter also does not include a description of the criteria, clinical guideline or medical policies that the Plan relied upon when reaching its determination that the requested service was not medically necessary. The letter's reference to the enrollee's EOC is insufficient as a citation to a criteria, clinical guideline or medical policy. In addition, the letter does not contain any clinical reasons to support the Plan's decision.

TABLE 1
Expedited Grievance File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Expedited Grievance	65	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.	50 (77%)	15 (23%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds the Plan has taken steps to correct this deficiency. However, the Department's file review showed that the Plan does not consistently provide a description of the criteria, clinical guidelines and/or medical policies in addition to the clinical reasoning relied upon when reaching its determination that the requested service was not medically necessary.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected and will be referred to the Department's Office of Enforcement.

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

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).

Plan's Follow-Up Compliance Effort: In addition to the corrective actions described in the Final Report, the Plan reported it has taken the following actions to address this deficiency:

The Plan explained that beginning in April 2017, it had instituted a daily monitoring process to ensure oversight when reviewing emergency room claims, and a process to report the Plan's audit findings for claims operations to the National Claims Administration-CA Bi-weekly Audit Readiness Committee.

On July 12, 2017, the Plan conducted training for Plan staff handling emergency service claims. The training clarified the difference between the "prudent layperson" and "reasonable person" standards, and explained that the reasonable person standard contemplates the enrollee's subjective viewpoint when determining whether the enrollee experienced an emergency medical condition. The Plan also provided individual training to staff who improperly denied emergency room claims.

The Plan revised all Policies and Procedures and operational documents to exclude the improper term, "prudent layperson standard" as a basis for denying emergency room claims. The term was replaced with the "reasonable person" standard.

Effective March 2018, the Plan implemented an automated alert that provides Plan staff with instructions to properly process emergency room claims.

Supporting Documentation:

- *Visio-ER Denial Control Process.* This diagram illustrates how the Plan provides a daily monitoring process for emergency room claims. If erroneous emergency room claim denials are identified, these claims are promptly addressed and corrected. A report is sent to the National Claims Administration-CA Bi-weekly Audit Readiness Committee, which reviews the report and sends it to the appropriate Plan division to conduct root cause analysis.
- *ER Control Report Example* dated March 2018. The spreadsheet demonstrates that the Plan reviews emergency room claims to ensure they are not erroneously denied.
- *Audit Readiness Minutes dated March 21, 2018.* The National Claims Administration-CA Bi-weekly Audit Readiness Committee minutes reflect discussions regarding the Department's Survey findings. The notes discuss that the Plan did not apply the appropriate review standard when reviewing emergency room claims, and that the Plan's written response when denying emergency services based in whole or in part on medical necessity does not include a description of the criteria or guidelines used along with the clinical reasons for the decision.
- *Clinical Review Training dated July 2017*. The document discusses training regarding the Department's finding that the Plan had inappropriately denied payment for emergency services. The training clarified the difference between the "prudent layperson" and "reasonable person" standards, and emphasized that the Department found that the Plan improperly used the "prudent layperson" terminology, and had denied emergency claims without contemplating whether the enrollee had experienced an emergency medical condition from the enrollee's subjective viewpoint.
- A list of all revised Plan Policies and Procedures and operational documents for review of emergency claims. These documents removed the term "prudent layperson standard" as a review standard and replaced it with the term "reasonable person standard."

Follow-Up Survey Assessment: The Department's review of the Plan's documents established the Plan no longer utilizes the term "prudent layperson" in its policies and procedures and operational documents to review emergency claims. The Plan's training

documents also demonstrate that Plan staff have been trained regarding the appropriate review standard when reviewing emergency claims. The Plan's documents also provided evidence that the Plan is providing daily oversight of emergency claims and is monitoring for erroneous emergency room claim denials, and any irregular findings will be reported and reviewed by the National Claims Administration-CA Bi-weekly Audit Readiness Committee.

File Review

For the Follow-Up Survey period, the Department's review established that the Plan reported no denials of emergency claims on the basis of application of either the prudent layperson or reasonable person review standard. In response to the Department's request, the Plan produced four denial files for Northern California and 41 denial files for Southern California. However, the Department did not consider these files because the Plan denied them on an administrative basis, and not a clinical basis.

However, the Plan acknowledged these emergency claims were incorrectly denied on the basis of administrative error. The Plan explained the files had been incorrectly routed through the Plan's computer system. The Plan re-emphasized that its policy is to pay all emergency claims. Finally, the Plan presented evidence that all of these administrative denials were paid, and that the responsible Plan staff were provided additional training.

Follow-Up Report Deficiency Status: Corrected

The Department's review of the Plan's documents established that the Plan has implemented a process to ensure that claims for out-of-plan emergency services will be appropriately reviewed and processed. The Plan's process has eliminated clinical review of these emergency claims, and Plan staff tasked with handling emergency claims are provided guidance to improve processing. The Plan is performing daily review of emergency claim denials, and any irregularities are reported and reviewed by the National Claims Administration-CA Bi-weekly Audit Readiness Committee.

The documents submitted by the Plan demonstrated that the term "prudent layperson" has been replaced with "reasonable person" in the Plan's Policies and Procedures and operational documents. Plan documents also demonstrated that Plan staff have been appropriately trained concerning application of the correct review standard for processing emergency claims. Finally, the Plan did not submit any files demonstrating denials based on a clinical basis.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been 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).

Plan's Follow-Up Compliance Effort: In response to the Preliminary Report, the Plan emphasized that it does not deny emergency room claims based on the failure to satisfy the reasonable person standard, and therefore in its denial letters, the Plan has no need to describe the criteria or guidelines used, or the clinical reasons for denial decisions. The Plan reiterated that the denied claims identified in Deficiency #5 were improper administrative denials and not denials based on medical necessity.

Nevertheless, in order to take corrective action, in January 2017 the Plan conducted training of Plan staff to discuss the appropriate standards for reviewing emergency claims, which included a component regarding appropriate response letters.

On July 12, 2017, the Plan also conducted retraining that discussed the Department's Survey regarding emergency room claim denials. The training clarified the difference between the "prudent layperson" and "reasonable person" standards, and emphasized that the Department found that the Plan improperly used the "prudent layperson" terminology, and had denied emergency claims without contemplating whether the enrollee had experienced an emergency medical condition from the enrollee's subjective viewpoint. The Plan also provided individual training to staff who improperly denied emergency room claims.

Supporting Documentation:

- *Clinical Review Training dated July 12, 2017*. The document is a Plan presentation that provided training to Plan staff regarding the Department's finding that the Plan had inappropriately denied payment for emergency services. The presentation emphasizes the correct review standard for reviewing claims for emergency services.
- *Audit Readiness Minutes dated March 21, 2018.* The National Claims Administration-CA Bi-weekly Audit Readiness Committee minutes reflect discussions regarding the Department's Survey findings that the Plan does not apply the appropriate review standard when reviewing emergency room claims, and that the Plan's written response when denying emergency services based in whole or in part on medical necessity, does not include a description of the criteria or guidelines used and the clinical reasons for the decision.
- Corrected versions of all Plan Policies and Procedures and operational documents for review of emergency claims that were revised to exclude the term "prudent layperson standard" as a review standard. For these Policies and Procedures and operational documents, the Plan has replaced the term "prudent layperson standard" with the term "reasonable person standard" which is a review standard for emergency claims that contemplates whether the enrollee had experienced an emergency medical condition from the enrollee's subjective viewpoint.

Follow-Up Survey Assessment: As discussed in Deficiency #5, the Plan did not submit any emergency denials files based on an assessment of the enrollee's subjective viewpoint regarding their medical emergency. Because the Plan's denial files were not based on medical necessity, the Plan's response letters were not required to contain a description of the criteria or guidelines used, and the clinical reasons for the decision. The Department therefore could not confirm via file review whether the Plan's emergency room denial letters now include a description of the criteria or guidelines used, and the clinical reasons for the decision.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan's corrective actions have prevented improper denials based on the prudent layperson standard. The Plan produced evidence that it has undertaken corrective action to implement a process to ensure that claims for out-of-plan emergency services will be appropriately reviewed and processed. In the event the Plan denies emergency claims by applying the reasonable person standard, the Plan produced evidence that Plan staff were trained regarding the requirements of the Plan's response letters to include a description of the criteria or guidelines used, and the clinical reasons for the decision.

As noted in Deficiency #5, the Plan did not produce any files containing denials based on medical necessity, and therefore the Department was unable to determine whether the Plan's denial letters include a description of the criteria or guidelines used, and the clinical reasons for the decision. However, the Department will re-evaluate this issue with file review during the 2019 Routine Survey.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been corrected.

SECTION II: SURVEY CONCLUSION

Issuance of this Follow-Up Report concludes the Routine Survey of the Plan. The Department finds that the Plan has corrected three of the six deficiencies that remained uncorrected upon issuance of the Final Report on June 12, 2017. As indicated in this Report, the Department will continue to monitor the Plan's progress related to Deficiency #1 and #2 through the deliverables referenced in the 2017 Settlement Agreement and review the Plan's QA Program during the 2019 Routine Survey.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), 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 Follow-Up 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 Follow-Up Report via the DMHC Communication tab.

As a reminder, 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 the document is being filed as a result of a deficiency identified by the Division of Plan Surveys.

Deficiency #4 in this Report remains uncorrected and will be referred to the Department's Office of Enforcement.