DEPARTMENT OF
Managed
Health Care
Help Center

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC

BEHAVIORAL HEALTH SERVICES

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Final Report of a Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
Behavioral Health Services
March 6, 2013

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EXECUTIVE SUMMARY

On January 6, 2012, the California Department of Managed Health Care (the "Department") notified Kaiser Foundation Health Plan, Inc. (the "Plan") that its Routine Medical Survey had commenced, and requested the Plan to submit information regarding its health care delivery system.

The survey team conducted the onsite portion of the survey from March 12, 2012, through March 15, 2012, and from March 19, 2012, through March 22, 2012. The Department completed its investigatory phase and closed the survey on July 25, 2012.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care

The Department identified **four** deficiencies during the current Routine Medical Survey. The 2012 Survey Deficiencies table below notes the status of each deficiency.

2012 SURVEY DEFICIENCIES

ACCESS AND AVAILABILITY OF SERVICES	
#1	**The Plan does not ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards.** (Rules 1300.67.2.2(c)(1) and (5); Rule 1300.67.2.2(d).)
#2	**The Plan does not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes.** (Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d).)
QUALITY MANAGEMENT/ ACCESS AND AVAILABILITY OF SERVICES	
#3	**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.** (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).)
HEALTH EDUCATION SERVICES: MENTAL HEALTH PARITY	
#4	**The Plan does not provide accurate and understandable effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated with the Plan.** (Section 1374.72; Rule 1300.67(f)(8); and Rule 1300.80(b)(6)(B).)

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 Medical Survey of a Plan that covers five 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 regulating utilization, 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 Management – 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 reasonable 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.

The Preliminary Report was issued to the Plan on August 8, 2012. 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. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Medical Survey of the Plan, which commenced on January 6, 2012 and closed on July 25, 2012.

PLAN BACKGROUND

The Plan arranges for health care services for over 6.8 million members in California through a comprehensive and integrated health care delivery system, including behavioral health, ambulatory care, preventive services, hospital care, home health care, hospice, rehabilitation services, and skilled nursing services. The Plan obtained its Knox-Keene license in 1977 serving the major areas of Northern and Southern California. The Plan's behavioral health system

[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.

includes the Departments of Psychiatry and Addiction Medicine located within medical centers and facilities in both regions.

Kaiser Permanente consists of three legally separate groups of entities: 1) Kaiser Foundation Health Plan, Inc., which holds the Knox-Keene license, 2) Kaiser Foundation Hospitals, and 3) the regional Permanente Medical Groups. Each entity has an independent Board of Directors.

The Plan's Northern California regional operations, headquartered in Oakland, California, serves approximately 3,351,499 members through its network of medical centers, which consists of 21 hospitals with four medical centers having multi-campus licenses, and 233 medical offices. Sub-regions include East Bay, Golden Gate, South Bay, Valley, Fresno, North East Bay and Stanislaus County. The Plan's regional medical group for Northern California is the Permanente Medical Group, Inc. (TPMG), which is a for profit multi-specialty physician corporation. TPMG's contracted professionals provide outpatient behavioral health care.
The Plan's Southern California regional operations, headquartered in Pasadena, California, serves approximately 3,499,035 members through its network of 14 medical centers and 198 medical offices. Sub-regions include the Coachella Valley, Kern County, Orange County, the Valleys, western Ventura County, Inland Empire, metropolitan Los Angeles/West Los Angeles, San Diego County, and Tri-Central. The Plan's regional medical group for Southern California is the Southern California Permanente Medical Group (SCPMG), which is a for-profit multi-specialty Physician partnership.

SCPMG's contracted providers provide most outpatient behavioral health care; however, SCPMG subcontracts with the Windstone Behavioral Health Group to provide triage, referral, network access, and claims payment services in the greater Palm Desert/Coachella Valley. This arrangement serves approximately 25,000 enrollees. SCPMG reimburses Windstone on a capitation basis and oversees its services.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On August 8, 2012, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan 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

ACCESS AND AVAILABILITY OF SERVICES

Deficiency #1: The Plan does not ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards.

Statutory/Regulatory Reference: Rule 1300.67.2.2(d) requires each plan to have written quality assurance systems, policies, and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Knox-Keene Act. Compliance monitoring policies and procedures, designed to accurately measure the accessibility and availability of contracted providers, must include tracking and documenting network capacity and availability with respect to the standards set forth in Rule 1300.67.22(c).

See also Rules 1300.67.2.2(c)(1) and (5).

Factual Findings: In Northern California, the Plan calculates appointment wait times from data entered into the Patient Appointment Registration Reporting System (PARRS). The Plan compares the booked dates of appointments with the enrollees' check-in (seen) dates. The Plan generates reports ("The Clinic Accessibility Report by Facility") from the system data for the Department and for monthly internal monitoring.

The Department found that some medical centers and facilities were able to customize PARRS beyond established Plan policies and procedures. This resulted in the following appointment practices:

1) Paper wait lists: The Plan and its medical group officers confirmed during interviews that when no appointment slots were available, a small number of facilities used paper waiting lists or requested the enrollee to call back when the next window to book appointments opened. As a result, the Plan/PARRS calculates wait times based erroneously on the next available booking date rather than on the date of the enrollee's original/initial request for an appointment.

2) If an appointment date is changed, the system does not retain a history of booking dates. The system's last booking date is applied to wait time calculations. Therefore, if a provider changes the appointment date, the Plan/PARRS calculates the wait time between the last booked date and the date of the new appointment, which excludes the wait time from the date of initial appointment request. This results in inaccurate reports of wait times that are shorter than actual wait times.

3) For consultation requests, the Plan's Psychiatry Department has two days in which to contact the enrollee and book an appointment. The Plan/PARRS calculates wait times from the date the appointment was booked rather than the date of the initial consultation request. This results in inaccurate reports of wait times that are shorter than actual wait times by up to two days.

4) In at least one medical center, the enrollee may receive an appointment without an assigned provider (e.g., the enrollee is overbooked with an expectation of an opening due to a no-show). Upon arrival, the clinic assigns the enrollee to a provider. In the system, this appears as a wait time of zero. The Plan and its medical group officers stated that the Plan has corrected this error, and the system now records the original request date.

Explanation of Deficiency: Rule 1300.67.2.2 requires the Plan to design and implement a monitoring system to *accurately* measure the accessibility and availability of contracted providers in accordance with the regulatory standards. Here, the Plan's access system does not accurately calculate, measure, and monitor the wait times of scheduled appointments, because it relies upon data from the Plan's providers, who do not follow procedures to ensure that the *initial* date of an appointment request is properly recorded and used in the calculation of wait times. Therefore, the Plan is in violation of Rule 1300.67.2.2.

Implications: Inaccurate data leads to inaccurate reports, which hinders the Plan's ability to effectively identify access problems, and to take action to resolve those problems. Enrollees who suffer from excessive wait times at underreported medical centers and facilities may continue to experience delays of health care services, deterioration of the enrollees' conditions, and dissatisfaction with the Plan's service and care.

Process or System Deficiencies That Need to be Addressed:[2] The Plan has taken steps to eliminate the use of paper wait lists, expand appointment-booking windows, and allow the system to accurately capture all appointments. However, the Plan should not only take steps to correct the practices discussed above, but should also include a process to disseminate the procedures, remedial training for staff responsible for scheduling appointments and establish and implement an accurate process/system tracking, measuring and monitoring timely access.

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

Plan's Compliance Effort: To address this deficiency, the Plan reported that it implemented a four-part strategy. First, to correct the system barriers, the Plan explained that both electronic

[2] This guidance is offered only as preliminary discussion points for the Plan to consider when determining its corrective actions for a deficiency. Corrective actions based solely on following this guidance may not necessarily correct the deficiency.

appointment-management tools; KP Health Connect in Southern California and PARRS in Northern California were reconfigured to ensure adherence to Plan policies and the Timely Access Regulations. The Plan described the following system revisions.

1) The PARRS system was reconfigured at all locations to permit new appointments to be scheduled at least four weeks in advance. As confirmation, the Plan provided screen prints demonstrating the change.

2) To ensure that PARRS retains a history of appointment booking dates and captures the total wait time between the time the initial appointment was booked and the time the rescheduled appointment was scheduled, the Plan will run a report identifying provider initiated rescheduled appointments and the time elapsed time from the initial booking time. Beginning January 2013, Northern California access reports will utilize the total amount of elapsed time for provider initiated rescheduled appointments. For those instances where the enrollee is requesting a rescheduled appointment, the Plan states that PARRS has and continues to capture the wait times between the enrollee's revised request and the date the enrollee is seen.

3) The Plan asserts that although the Plan's Psychiatry Department has two days in which to contact the enrollee and book an appointment, in most cases, this is done on the same day. In addition, the Plan is able to identify those enrollees who have not been contacted on the same day as the eConsult (the consultation request) was generated. In order to capture any elapsed time between the date of an eConsult being created and the time the initial appointment is booked (in PARRS), the Plan will use the initiated date of the eConsult rather than the booked date of the appointment within PARRS to generate the access reports.

4) Where it was identified that the enrollee may receive an appointment without an assigned provider until the enrollee arrives for the appointment resulting in an appointment wait time of zero, the Plan has initiated a technological solution that allows changing/inserting the name of the provider who sees the enrollee, without having to change the original appointment request date. The Plan states that this new process was initiated, and validated in four different locations between May and July of 2012.

In its response to this deficiency, the Plan provided training materials used to train behavioral health managers and directors, and all personnel who schedule behavioral health appointments. The Plan states that it received confirmation that between April and September of 2012, all had received this remedial training.

Ongoing Performance Monitoring:

As part of its ongoing review processes, the Plan states that its Compliance Department will conduct validation audits during the first quarter 2013 on the electronic appointment systems to ensure that appointment dates, types, and wait times are accurately captured in the electronic appointment system and that no paper wait lists are being used. The Plan provided the tool its Compliance Department will use to monitor the ongoing training referenced above. If the audit reveals a deficiency, the Plan stated that the Compliance Department would work with the Plan and Medical Group leaders to develop a CAP with specific timelines and milestones. The first audit is scheduled for the first quarter 2013.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that by instituting system and process improvements, subsequently training its staff, and developing a mechanism with which it may validate compliance with policies and the Timely Access Regulations, the Plan has initiated actions towards correcting this deficiency. However, as the Plan has not yet begun to perform the validation audits, the Department cannot determine compliance. Within the next six months, the Department will commence a Follow Up Survey to review the validation audit findings and any resulting CAPs to ensure this deficiency is corrected. Additionally, these matters will be immediately referred to the Department's Office of Enforcement.

Deficiency #2: The Plan does not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes.

Statutory/Regulatory Reference: Rule 1300.67.2.2(c)(1) states, "Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard."

Rule 1300.67.2.2(c)(5) requires each plan to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

- Urgent care appointments for services by a Physician or non-physician provider that do not require prior authorization: within 48 hours of the request for appointment,
- Non-urgent appointments with specialist Physicians, such as psychiatrists: within fifteen business days of the request for appointment,
- Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment.

Rule 1300.67.2.2(d) requires each plan to have written quality assurance systems, policies and procedures designed to ensure that the Plan's network is sufficient to provide accessibility, availability, and continuity of covered health care services of contracted providers. These procedures shall include tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c).

Factual Findings: For each service area[3], the Plan calculates an "Average Days Wait" (i.e. an average of the days waited for each appointment) for four appointment categories: 1) urgent appointments with primary care Physicians, 2) non-urgent appointments with primary care Physicians, 3) urgent appointments with specialists, and 4) non-urgent appointments with specialists.

The Plan uses the reported appointment wait times from each medical center in a service area to calculate the Average Days Wait for that service area. If the Average Days Wait in all four appointment categories is found to be compliant, the Plan deems that service area 100 percent compliant. If the Average Days Wait fails to comply in any category, the compliance rate for that category is zero percent. Therefore, when the Plan averages the compliance rate of the four categories for a service area, that service area's compliance rate will be zero percent, 25 percent, 50 percent or 100 percent.

The regulatory standard for non-urgent appointments with a non-physician mental health provider is 10 business days (or 14 calendar days as filed by the Plan).[4] If the Average Days Wait for this appointment type equals 14 calendar days or less, the Plan reports the service area as compliant with this standard.

The Department found that, in practice, the Plan's methodology for calculating compliance hinders the Plan's ability to detect patterns of non-compliant wait times and leads to incomplete compliance reports. By averaging the number of days waited for each appointment, the Plan's methodology offsets a pattern of long wait times with shorter wait times. Using only an average of all wait times does not reveal trends or patterns of non-compliant wait times. In practice, a number of the medical centers' monthly wait times appeared to be compliant (i.e., had an average of 14 calendar days or less) even though up to 40 percent of their appointments may be one or more days over the 14-day standard.

For example, Southern California Medical Center A's Service Area's reported Average Days Wait, from February 2011 through February 2012, ranged from eight to 14 days for each month. However, when the Department evaluated the appointment wait times individually, it found that between 17 percent and 40 percent of the wait times exceeded 14 days.[5] For May 2011, the area's Average Days Wait was 14 days; however, the Department found that 40 percent of wait times exceeded 14 days. For the 13-month period, during which 6,479 visits were booked, over 1,700 appointments (26 percent) were <u>not</u> booked within 14 days.

Southern California Medical Center B's Service Area's reported Average Days Wait met the 14-day standard in 11 of 13 months, yet 18 percent of the wait times exceeded 14 days. The last three reported months, which reported the lowest/best Average Days Wait,[6] the Department found that between 18 percent and 32 percent of the wait times exceeded 14 days. Thus, for this

[3] The two regions are Northern California and Southern California.

[4] In lieu of business days, the Plan calculates its wait times using an equivalent in calendar days (i.e., 14 calendar days instead of 10 business days for non-physician non-urgent appointments, and 21 calendar days instead of 15 business days for specialist Physician appointments).

[5] The Plan uses the formula [Total # Appointments booked within 14-day standard/Total # Appointments booked in the current month] to calculate the Percent Booked within the standard. The denominator includes scheduled patients who were "No Shows," which is approximately 13-14 percent a month.

[6] Average Days Waits, 10, 10 and 9 days respectively.

three-month period, during which 2,365 visits were booked, the wait times for over 450 appointments exceeded 14 days.

Explanation of Deficiency: Rules 1300.67.2.2(c) and (d) require the Plan to establish quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards, which include offering enrollees non-urgent appointments with a non-physician mental health care provider within ten business days (or 14 calendar days) of the request for appointment.

Here, the Plan's methodology for monitoring appointment wait times relies on averaging all reported wait times for a given month. Although calculating the Average Days Wait may provide some insight into the overall monthly trend, the Plan's methodology does not account for each enrollee's wait time individually, and may mitigate or hide excessive wait times by averaging them with shorter wait times. Therefore, the Plan is in violation of Rules 1300.67.2.2(c) and (d), because its monitoring system, without accounting for wait times individually, did not alert the Plan to serious timely access issues for individual enrollees.

Implications: Enrollees with medical or mental health conditions must be seen by an appropriate health care provider within appropriate intervals (e.g. clinical, regulatory, etc.) in order to effectively treat the condition and/or prevent further deterioration of the enrollee's health. If the Plan does not effectively monitor wait times and ensure that enrollees are not waiting excessively for an initial appointment or between appointments with their provider, significant numbers of enrollees with untreated or prolonged health conditions may suffer harm.

Process or System Deficiencies That Need to be Addressed: Establish monitoring systems and processes that are sufficient to ensure that enrollees are receiving appointments within the regulatory standards set forth in Rule 1300.67.2.2 and would enable the Plan to identify trends and patterns of excessive wait times at all levels that require corrective action.

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

Plan's Compliance Effort: The Plan stated that it has strengthened its oversight mechanisms for access by revising its methodology, establishing two new access committees, developing new reports, and in some cases, implemented medical center service center level corrective actions.

1) *New Methodology***.** The Plan adopted a new methodology that measures access to appointments by behavioral health department, the actual percentage of initial appointments which had wait times within the applicable period under the timely access regulations. For example, the new methodology tracks the percentage of initial non-urgent non-physician behavioral health appointments that occurred within 14 calendar days of member request. The new methodology is referred to in this Report as "Percentage Requested to Seen". The Plan noted that this new methodology differs from Average Days Wait because it shows the percentage of appointments where the wait time was within the applicable period, rather than an average of all of the wait times for particular types of the appointments.

2) *New Committees and Responsibilities***.** The Plan formed new access committees in each region. The Northern California Access Committee is a sub-committee of the Quality Oversight Committee and was formed in July 2012. The Southern California Access Sub-Committee of the Member Concerns Committee is a sub-committee of the Southern California Quality Committee and was formed in August 2012. The Plan provided for the Department's review, copies of both of these access committees' charters. As a result of the changes above, three reports associated with behavioral health will be reviewed by each of the access committees:

> (1) Percentage Requested to Seen for initial appointments by timely access regulatory category, reviewed monthly: *Will show trended access data for urgent and initial non-urgent appointments in behavioral health, broken out by child and adult. The Plan is in the process of developing the appropriate template for the Percentage Requested to Seen and will determine over time the most effective reporting mechanism for this new methodology.*
>
> (2) Ratio of Providers to Members, reviewed quarterly; and
>
> (3) Average Days Wait for initial appointments by timely access regulatory category, reviewed monthly: *In Southern California, the Plan is in the process of developing template reports that will provide trended access information that includes both Percentage Requested to Seen and Average Days Wait during the previous twelve-month period*

The Northern California Access Committee began reviewing the reports in September 2012.

The Southern California Access Sub-Committee began reviewing performance and action plans based on Average Days Wait in August 2012, and recently began to review newly generated Percentage Requested to Seen data. For the Department's reference, the Plan attached a copy of the agenda for the Southern California's Member Concerns Committee - Access Subgroup Meeting that occurred on November 20, 2012.

The Plan stated that the reports identified above for each medical center will begin to be reviewed in January 2013 by the Area Manager (the Northern California Plan officer for the medical center) and the Executive Director (the Southern California Plan officer for the medical center) in collaboration with the Physician in Chief (for Northern California) or Area Medical Director (for Southern California). These health plan officers are accountable for monitoring access and any corrective action plans.

Additionally, these health plan officers will collaborate with the Area Medical Director or Physician in Chief to:

- identify potential or actual timely access compliance issues
- take responsibility for the development of required access compliance plans
- oversee the respective behavioral health departments' actions to remediate access compliance issues
- report issues and actions to the appropriate Access committee

Further, these health plan officers are responsible to ensure their local actions are aligned with any actions taken by the respective regional Access committees. In addition, each Area Manager

and Executive Director will collaborate with the Area Medical Director or Physician in Chief to understand member grievances and concerns associated with access, and to ensure appropriate responses and actions are developed regarding these issues raised by members.

In addition, both regional Access (Sub) Committees will report on access to the applicable regional Quality Committee on a quarterly basis beginning in 2013. In the event that either committee identifies issues that warrant more frequent attention, the Plan stated that the committee may escalate the issue outside of the regular report cycle to the applicable regional Quality Committee.

The Northern California Access Committee reported to the Quality Oversight Committee in November 2012. The Southern California Access Sub-Committee is part of the Member Concerns Committee and its findings will be included in the Member Concerns Committee report to the Southern California Quality Committee in December 2012.

The Plan explained that the Regional Quality Program Descriptions and Work Plans would be updated to include the activities of the new access committees in Northern California and in Southern California in Apri1 2013.

In response to the Department's findings in the Preliminary Report regarding this deficiency, the Plan provided information about its progress towards correcting non-compliance in various medical centers.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that by revising its methodology for measuring appointment wait-time, developing new reporting, establishing two regional committees whose purpose is to examine accessibility issues and ensure corrective actions are instituted, the Plan has initiated actions towards correcting this deficiency. However, the Plan did not submit detailed corrective action plans that include detailed assessments of the reasons or root causes for each area of non-compliance as directed by the Department in a letter to the Plan dated November 15, 2012. In addition, the Plan has projected to complete some of its corrective actions well into 2013.

The Department believes the findings discussed in this deficiency potentially pose significant access barriers for Plan members. Members with medical or mental health conditions must be seen by an appropriate health care provider within appropriate intervals in order to effectively treat the condition and/or prevent further deterioration of the enrollee's health. As such, the Department believes the described identified barriers to care require prompt action. These matters will be immediately referred to the Department's Office of Enforcement.

QUALITY MANAGEMENT/ ACCESS AND AVAILABILITY OF SERVICES

Deficiency #3: 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: Rule 1300.70(a)(1) requires the Plan's Quality Assurance Program to document that 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 a plan's Quality Assurance Program to address service elements, including accessibility, availability, and continuity of care.

Rule 1300.70(b)(1)(D) requires each plan's Quality Assurance Program be designed to ensure that appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason.

Rule 1300.70(b)(2)(G)(3) states, "Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following…Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities."

See also Rules 1300.67.2.2(c)(1) and (5) from Deficiency #2; and Rule 1300.67.2.2(d)(3).

Factual Findings: In Southern California, the Plan relies on Cadence, an appointment tracking system, to report appointment wait times. Cadence's "Percent Booked within Standards" measures the percentage of appointments falling within the regulatory timeframes. The appointments include non-physician intake, follow-up appointments, or physician intake appointments.

Cadence generates the Access Score Card Summary (see Table 1), which allows the Plan to identify poorly performing medical centers. The summary revealed that less than half of the appointments were booked within the regulatory timeframes for Southern California Medical Centers C, D and E.

TABLE 1

Access Score Card Summary Monthly

Name	Measure	Feb 2011	March 2011	April 2011	May 2011	June 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012
Med Center E Area	ADW % Booked within Standards	12 67%	14 38%	15 48%	13 77%	17 68%	19 37%	23 32%	20 42%	19 44%	13 57%	10 89%	8 94%	6 96%
Med Center C Area	ADW % Booked within Standards	10 73%	14 46%	12 54%	13 38%	15 47%	19 38%	18 44%	22 41%	23 42%	27 36%	19 51%	16 49%	13 40%
Medical Center D Area	ADW % Booked within Standards	12 62%	14 51%	15 42%	17 37%	21 34%	21 33%	19 37%	18 39%	19 37%	21 32%	21 30%	18 45%	15 51%

Although the Plan identified low percentages of compliant appointments for Southern California Medical Center E as early as February 2011, the summary revealed that significant improvements in wait times did not appear until December 2011. Between February 2011 and January 2012, Southern California Medical Center C's summary indicated seven continuous months of less than 50 percent of its appointments booked within the regulatory standards. For ten consecutive months (April 2011 – January 2012), Southern California Medical Center D had less than 50 percent of its appointments booked within the regulatory standards. These three medical centers also ranked among the lowest on the Plan's enrollee satisfaction survey for 2011 and 2012.

Between June and July 2011, initial mental health appointments in Northern California Medical Center A exceeding 15 days averaged seven percent.[7] However, beginning in September 2011 and continuing through January 2012 (five months), the monthly average rose to 60 percent of initial appointments exceeding 15 days.[8] The Plan and TPMG both acknowledged the seriousness of this issue. From June 2011 to January 2012 (eight months), Medical Center B reported a similar pattern with a monthly average of 43 percent of new appointments booked in excess of 15 days.[9]

The Plan identified causes of the above access issues including: 1) multiple, simultaneous staff absences, 2) increases in demand based on increased enrollment, 3) environmental conditions

[7] In June, 3 percent of appointments exceeded 15 days, In July, 12 percent of appointments exceeded 15 days.
[8] Between September 2011 and January 2012, Northern California Medical Center A averaged approximately 306 new patients per month.
[9] Northern California Medical Center B averaged 218 new patients per month from June 2011 to January 2012.

(e.g., economic conditions), 4) slow staff recruitment, and 5) inadequate office space to accommodate new hires.

Although the Plan has identified access problems and their causes, the Plan shifts responsibility onto the medical center and/or the medical group's clinical and administrative management to establish and implement corrective actions. The Plan primarily monitors and evaluates the results of the corrective actions, but does not assist in the resolution of these issues.

Explanation of Deficiency: Rule 1300.70 requires the Plan to develop a Quality Assurance Program that includes monitoring, evaluation, *effective* corrective action/resolution, and follow-up of identified availability and accessibility issues. The Rule also allows the Plan to use its medical groups' or other providers' active Quality Assurance Programs, but requires the Plan to retain responsibility for reviewing the overall quality of care delivered to its enrollees, and to have ongoing oversight to ensure that providers are fulfilling all delegated quality assurance responsibilities.

Here, the Plan, its medical groups, and its medical centers have identified access deficiencies regarding non-compliant appointment wait times. However, the Plan's reports show that these access deficiencies remained unresolved or, if resolved, were resolved several months after the date of the initial identification. Therefore, it appears that the Plan does not ensure that its Quality Assurance Program, its medical groups, and its medical centers are taking effective action to improve care where deficiencies are identified, which violates Rule 1300.70.

Implications: The Plan's failure to ensure timely access to appointments, and to take effective action to improve care where deficiencies are identified may result in delays of health care services, deterioration of enrollees' conditions, and enrollee dissatisfaction with service and care.

Process or System Deficiencies That Need to be Addressed: The Plan, its medical groups, its medical centers, and any Plan delegated quality assurance function should promptly establish and implement corrective actions to resolve the systemic access deficiencies already identified by the Department and the Plan. The Plan should report to the Department its corrective actions and improvements to the deficiencies as a result.

The Plan should also establish and implement a process to ensure that the Plan is monitoring and overseeing its medical groups and its medical centers and that documentation of prompt and effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Plan should also establish effective ongoing oversight procedures to ensure that providers are fulfilling all delegated quality assurance responsibilities.

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

Plan's Compliance Effort: The Plan responded that it has established the following indicators warranting the Plan to make specific inquiries to either TPMG or SCPMG leadership for an explanation of performance and/or initiation or revision of a CAP:

(a) Percentage Requested to Seen for initial appointment is less than 80 percent for a quarter; OR
(b) Average Days Wait for initial appointments is below the timely access standard for a quarter.

The Plan stated that it chose 80 percent as the indicator for the new methodology, Percentage Requested to Seen, in order to take into account three considerations:

(1) There will be always be appointments booked outside of the time periods to accommodate the member's personal schedule
(2) The Plan measures booked to seen, rather than to first offered appointment and the member may not want the first appointment offered
(3) The timely access regulations explicitly provide that the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance

The Plan explained that it believes that when its departments fall below 80 percent within the applicable time-period it is a reasonable indication of the need for specific inquiries and potential corrective action.

Upon notice from the Plan in reference to the indicators above, the Medical Group will provide the Plan with an explanation and, if requested by the Plan, a proposed CAP within 30 days. The Plan explained that it would annually review the indicators and modify the indicators as necessary to ensure effective identification of potential issues warranting inquiry and appropriate response. In addition, at any time, Plan or Medical Group leadership or either of the regional Access Committees may make additional inquiries and respond to areas of concern based on demonstrated failures to meet access requirements. CAPs will require departments to quantify their projected demand for appointments and their projected supply. Where a deficit exists, the departments are asked to reconcile this gap by specifically accounting for how they intend to provide the required supply. In addition, the departments must identify the date when they expect to be in compliance. If CAPs do not adequately address the identified need, the plans are returned for modification and, when necessary, escalated to appropriate leadership. All CAPs are presented to the respective Access committees referenced below.

The Plan further explains that any CAP will be reviewed monthly for adequacy and progress at either the appropriate Access Committee and by either the Executive Director (the Southern California Plan officer for the medical center) or the Area Manager (the Northern California Plan officer for the medical center) in collaboration with the appropriate Medical Group leader. In the event the department does not show significant improvement within 60 days after CAP implementation, at the Plan's request, the department will develop a new CAP, which must be approved by the Plan before implementation. In addition, if warranted, the Plan stated that it will request and receive additional data and/or meet with TPMG or SCPMG leadership to review access issues. The Southern California Access Sub-Committee continues to monitor the specific medical center service areas that the Department noted require improvement.

In response to the Department’s findings in the Preliminary Report regarding wait times at specific medical centers, the Plan provided information about its progress toward correcting non-compliance at those centers.

Department's Finding Concerning Plan's Compliance Effort:

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

The Department finds that although the Plan has instituted changes to its methodology for measuring wait time for appointments, established committees to monitor compliance with the time-elapsed standards and reported on the corrective actions it implemented for certain medical centers, the Plan should address the following:

1) The Plan's 80 percent indicator may result in misleading Timely Access regulation compliance statistics being reported to the Department. Rule 1300.67.2.2(c)(5) requires plans to ensure that **enrollees** are offered appointments consistent with clinical appropriateness and within specified timeframes. The Plan's proposal to report that any medical center achieving a greater than 80 percent Percentage Requested to Seen for initial appointments in a quarter as compliant with Timely Access regulations is non-compliant. Both the Plan's internal monitoring and its reporting to the Department must reflect the actual rate of compliance, not a blended average or a report of 100 percent compliance where an artificial benchmark, such as 80 percent, is met. Under the Plan's proposed standard, the Plan does not consider corrective action until more than twenty percent of Plan members in a particular medical center service area requesting an appointment cannot obtain an appointment within the mandated timeframes. This does not take into account the specifics of the access problem and still allows for significant deviations from the standard of care to be offset—for example, patterns of non-compliance involving a single provider or a short period of time without adequate provider coverage. The Plan's monitoring must allow for individual assessments of the facts involved. It is not adequate to deem 80 percent as compliant as a rule for internal monitoring. In addition, the actual percentage of compliance must be reported to the Department, not a percentage of how often the 80 percent benchmark is met, otherwise the Department cannot monitor changes and improvement over time and compare the Plan to other plans.
2) The Plan's response did not include detailed descriptions or documentation and the Plan's assessment of any corrective actions implemented by the medical groups based on the issues identified, discussed or assessed in-depth from the report reviews. Rule 1300.70 requires the Plan to develop a Quality Assurance Program that includes monitoring, evaluation, *effective* corrective action/resolution, and follow-up of identified availability and access issues. The Rule also allows the Plan to use its medical groups' or other providers' active Quality Assurance Programs, but requires the Plan to retain responsibility for reviewing the overall quality of care delivered to enrollees, and to have ongoing oversight to ensure that providers are fulfilling all delegate quality assurance responsibilities. If the Plan is relying on medical groups to effectuate corrective action, it must monitor corrective actions closely and provide documentation of that oversight to the Department.

The Department believes that findings discussed in this deficiency to be serious with potential to bar timely access to needed care for a significant number of the Plan's members. As such, the Department will closely monitor the Plan's prompt correction of these substantial barriers to accessing care in part by conducting a Follow Up Survey within six months. Due to the nature

of the violations uncovered, these matters will be immediately referred to the Department's Office of Enforcement. The Plan is also reminded that its October 2010 Timely Access implementation filing contains an obsolete methodology that was found to be non-compliant in practice. An amendment must be filed to reflect changes. The Department, including the Divisions of Licensing and Plan Surveys, will review that filing.

HEALTH EDUCATION SERVICES: MENTAL HEALTH PARITY

Deficiency #4: The Plan does not provide accurate and understandable effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated with the Plan.

Statutory/Regulatory Reference: Rule 1300.67(f)(8) provides that the basic health care services required to be covered by the Plan include effective health education services, including information regarding the optimal use of health care services provided by the Plan or health care organization affiliated with the Plan.

Rule 1300.80(b)(6)(B) provides that the Department's medical surveys shall include a review of the availability of health education to enrollees.

Section 1374.72 requires plans to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions.

Factual Findings: At the provider level, educational materials help provide information to enrollees about available mental health services. Examples of enrollee materials include "Frequently Asked Questions" (FAQ) sheets, Web site postings, and new patient PowerPoint presentations. The Department identified statements in some of these enrollee materials that reference coverage limitations or exclusions for mental health benefits without the required exception for treatment of a severe mental illness (SMI) or serious emotional disturbances of a child (SED). Moreover, these materials improperly state that long-term individual therapy is unavailable to enrollees.

Examples of these materials containing statements with legal deficiencies include:

1) A FAQ sheet from Northern California Department of Psychiatry A, states:

> **Question:** "How many sessions [individual psychotherapy] will be involved?"
>
> **Answer:** "We offer brief, problem solution-focused individual counseling. Research shows many people improve in a single visit. For others, 3 to 6 visits can produce desired changes. You and your provider will work together to assess your progress and determine your needs. We do not offer long-term individual psychotherapy at Kaiser."

2) A website, maintained by the Northern California Department of Psychiatry B states:

> Please note that only conditions that are subject to improvement through relatively short-term therapy are covered**.** Patients requiring ongoing medication management can be followed for longer periods of time.
>
> *Services Not Covered*
> It is important to clarify what we do not offer, as well as what we do offer. In general, we do not begin treatment with individuals whose problems are of such a long-standing nature that short-term treatment would probably not be helpful (such as chronic mental illness, lifelong personality problems etc.). We will refer such individuals to an appropriate non-Kaiser facility, although this treatment will not be a Kaiser covered benefit and will not be paid for by Kaiser.

The Department also found examples of member materials that, while literally consistent with the law, did not convey coverage in language understandable to the average member. For example:

3) The *Introduction for Patients*, used in the Plan's Northern California Medical Center A facilities, states:

> "Health Plan contracts for up to 20 visits per calendar year with various copayments. The number and type of visits provided will depend on the diagnosis and will be decided by the therapist. Under AB88 parity legislation, all treatments for parity diagnosis are covered for medically necessary conditions."

Although literally in conformance with the law, the above statement's meaning would be lost on most members, who would not recognize the reference to "AB 88 parity legislation," and would not understand that, if the members had a serious mental illness, they would have coverage for mental health treatment as medically necessary, with no visit limits.

There is evidence that these inaccurate educational materials may dissuade an enrollee from pursuing medically necessary care. The Department found differences in the utilization rate of individual mental health appointments between Northern (where the materials in question were distributed) and Southern California. While this may be partially attributed to a different treatment approach,[10] it may also be exacerbated by the use of a 14-day only appointment-booking window, which significantly limits the scheduling of longer-term mental health appointments, and precludes the Plan's ability to pre-schedule a patient for several individual appointments over a two to three month period. This means that even if the treating provider developed a treatment plan that included long-term psychotherapy, the provider is likely to encounter barriers in the delivery system.

Explanation of Deficiency: The materials cited in this deficiency contain statements advising enrollees that medically necessary care for chronic conditions and long-term psychotherapy is not available to them. These statements are in error because the Plan is required to provide coverage for serious mental illnesses under the same terms and conditions as medical conditions. The Plan is also required to provide health education to enrollees, including recommendations regarding the optimal use of services provided by the Plan or health care organizations affiliated

[10] Senior Physician Management for Northern California cited literature reviews advocating the use of group therapies as an adjunct to individual treatment, medication management, and educational offerings.

with the Plan.[11] The Department is required to review the availability of health education to enrollees as part of the continuity of care portion of the Routine Medical Survey.[12] While the Plan has educational materials available at facilities, some of them describe limitations in benefits that are not compliant with the law, and contain misleading or confusing statements, as shown in multiple examples cited in this deficiency. These materials make recommendations that would act to *minimize* the use of certain health care services required to be covered by the Plan under the Mental Health Parity Act.[13] Therefore, the Plan does not provide effective health education services regarding its behavioral health program.

Implications: The Plan's failure to provide consistent and effective health education services, as shown in the inaccurate materials distributed to enrollees, may have discouraged some enrollees from seeking and accessing medically necessary behavioral health services.

Process or System Deficiencies That Need to be Addressed: The Plan must ensure all materials designed to inform members of available mental health services are consistent with the benefits and limitations set forth in the Plan's Evidence of Coverage, do not mislead enrollees regarding benefit coverage, or conflict with state or federal law. In addition, the Plan should conduct periodic audits of member materials published by its medical groups to prevent future misstatements of Plan benefits. The Plan should proactively provide effective health education services in the areas most affected by the inaccurate materials.

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

Plan's Compliance Effort: The Plan stated in its response that it recognizes the value of educational materials available from health care providers in informing enrollees about specific mental health conditions and the availability of mental health services. Kaiser Permanente also recognizes the importance of ensuring that such educational materials are current and accurate. As such, the Plan states that in Northern California, Kaiser Permanente removed or revised those materials identified by the Department.

- In Northern California Medical Center A, the document referenced in the Preliminary Report, "Information for Patients" was removed from the intake packets. Staffs in this medical center were instructed to refer any questions regarding Kaiser benefits to Member Services.

- The Plan stated that it confirmed that the Northern California Department of Psychiatry B website had been revised.

- In Northern California Department of Psychiatry A, the document, "FAQ Sheet" was obsoleted.

Furthermore, the Plan reported that TPMG conducted a review of all current facility websites and enrollee materials on behavioral health services and deleted any information that addressed

[11] Rule 1300.67(f)(8)
[12] Rule 1300.80(b)(6)(B)
[13] Section 1374.72

benefit coverage. In addition, TPMG provided the Plan with an inventory of the facility websites reviewed and a summary list of the revised web page materials.

Although there were no specific examples identified in Southern California, the Plan stated that the region also conducted a review to ensure accurate materials are used. In Southern California, the behavioral health departments at all of the Southern California medical centers reviewed over 95 documents. It was found that most of the materials were of a clinical nature rather than a description of health plan benefits, therefore no changes were necessary.

In order to prevent such inaccuracies in the future the Plan is taking the following steps. The Medical Groups have agreed that any written materials used by either group that describe Health Plan benefits will be reviewed and approved by the Plan prior to use with enrollees. This agreement will be reflected in a policy and procedure that will be prepared and implemented by March 31, 2013. The Plan's Compliance Department will conduct validation audits to review facility websites and enrollee materials for information that incorrectly addresses benefit coverage. The audits will occur beginning the first quarter of 2013.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

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

The Department finds that by revising websites, removing identified material from use, and devising a comprehensive validation audit tool, the Plan's corrective responsive appear to address this finding. However, to make an accurate compliance determination, the Department must evaluate the Plan's new policy and analyze the results of the Plan's validation audit. The Department will commence a Follow Up Survey within the next six months to review the Plan's corrective actions regarding this deficiency. Additionally, these matters will be immediately referred to the Department's Office of Enforcement.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Medical Survey. The Department will conduct a Follow-Up Review of the Plan and issue a report within 12 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, **2012 Routine Behavioral Health Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.

Plan Response to the Final Report