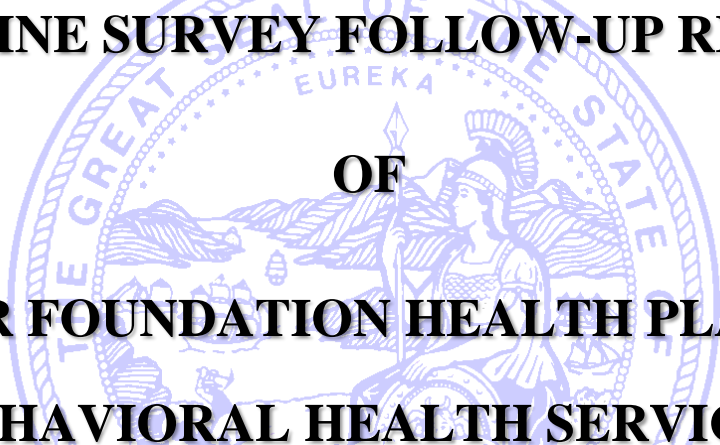


DEPARTMENT OF
**Managed
Health Care**
Help Center

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

ROUTINE SURVEY FOLLOW-UP REPORT
OF
KAISER FOUNDATION HEALTH PLAN, INC.
BEHAVIORAL HEALTH SERVICES

The seal of the State of California is visible in the background, featuring the word 'EUREKA' at the top, 'THE GREAT SEAL OF THE STATE' around the perimeter, and 'CALIFORNIA' at the bottom. The central figure is a woman holding a scale and a sword, with a grizzly bear at her feet.

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**Routine Survey Follow-Up Report
Kaiser Foundation Health Plan, Inc.
Behavioral Health Services
February 13, 2015**

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EXECUTIVE SUMMARY

Background

On March 6, 2013, the Department of Managed Health Care (“Department”) issued its Final Report concerning the routine medical survey of behavioral health services for Kaiser Foundation Health Plan, Inc. (“Kaiser” or “Plan”). In the Final Report, the Department identified four uncorrected deficiencies related to the Plan’s delivery of mental health services to its enrollees and informed the Plan that a Follow-Up Survey would commence within six months.

Because of the serious nature of the deficiencies identified in the Final Report, the Division of Plan Surveys prepared an immediate referral to the Department’s Office of Enforcement. The Office of Enforcement investigated the matter further, and then the Department issued a Cease and Desist Order commanding the Plan to cease from engaging in the conduct identified in the violations, and filed an Accusation imposing an administrative penalty in the amount of four million dollars (\$4,000,000.00). Although the Plan requested a hearing concerning the administrative penalty, the Plan decided to pay the penalty shortly after the hearing commenced.

The Follow-Up Survey, to determine whether the Plan had fully corrected the outstanding deficiencies, commenced in July 2013. The onsite portion of the survey was conducted during October 2013, March 2014, and April 2014. Throughout the remainder of 2013 and 2014, the Division of Plan Surveys continued work on the Follow-Up Survey and held several meetings with representatives from the Plan to gather additional information concerning corrective actions the Plan had taken to address the deficiencies identified in the Final Report.

Summary of Deficiencies

The Department has determined that Deficiencies #1 and #2 have been corrected by the Plan. However, Deficiencies #3 and #4 have not been corrected.

In *Deficiency #1*, the Department found that the Plan failed to track and capture data necessary to determine whether mental health services are delivered within the timeframes specified in the Timely Access to Non-Emergency Health Care Services regulation, (Title 28, C.C.R., section 1300.67.2.2.). The Final Report identified four specific actions that prevented the Plan from capturing and tracking information needed to determine timely access compliance. In this Follow-Up Survey, the Department concludes that the Plan has taken steps to correct the problems identified in the Final Report.

However, during the Follow-Up Survey process, the Department identified an additional issue related to the Plan’s tracking of timely access to services when enrollees receive services from externally-contracted providers. In late 2014, the Plan changed its processes so that it now tracks timely access for its largest and most frequently used external provider network in the Northern Region. The Department has informed the Plan that it needs to ensure that timely access is tracked for all externally-contracted providers to whom patients are referred for services. Additional review of the Plan’s processes for monitoring timely access for externally-contracted providers will occur during the next Routine Survey. Accordingly, the Department concludes that Deficiency #1 has been corrected.

In *Deficiency #2*, the Department identified serious concerns regarding the methodology utilized by the Plan to determine timely access compliance and to report compliance data to the Department in connection with mandated annual reports. The Follow-Up Survey confirmed that the Plan filed an amendment with the Department describing the new methodology now used by the Plan to track timely access to services. Accordingly, the Department concludes that Deficiency #2 has been corrected.

In *Deficiency #3*, the Department found that the Plan's Quality Assurance Program failed to ensure that effective action is taken to improve care when deficiencies are identified, including those related to accessibility and availability of services. Prior to reaching its determination regarding Deficiency #3, the Department reviewed extensive internal changes made by the Plan following issuance of the Final Report, as well as Plan-generated access performance reports for certain medical centers and departments. The Department also conducted an extensive medical records review, examining 297 individual patient charts regarding access to initial and follow-up mental health care. In addition, the Department met with the Plan on several occasions to gain a better understanding of how the Plan responds to situations involving timely access deficiencies.

Although the Plan has made significant strides toward correcting deficiencies concerning its obligation to monitor and provide access to behavioral health services, based on the evidence obtained through the Follow-Up Survey process, including review of medical records and timely access performance reports, the Department concludes that the Plan's corrective actions have not sufficiently fixed the access-related problems identified. Review of medical records to assess appointment wait times and the Plan's timely access reports show volatility in timely access to behavioral health services in both regions. Therefore, the Department has determined that Deficiency #3 remains uncorrected.

In *Deficiency #4*, the Department found that the Plan failed to provide accurate and understandable behavioral health benefit and coverage education services. Although the Plan implemented policies requiring internal review of printed and on-line health education materials prior to making those materials available to enrollees, the Department's review of medical records conducted in connection with Deficiency #3 revealed individual cases in which providers disseminated, verbally, and in writing, inaccurate and misleading health education information to enrollees regarding the scope of their coverage for behavioral health services. Based on the information reviewed during the Follow-Up Survey, the Department concludes that Deficiency #4 remains uncorrected.

The Division of Plan Surveys referred this matter to the Office of Enforcement for further investigation and possible disciplinary action, based on the Plan's failure to correct Deficiencies #3 and #4.

FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON MARCH 6, 2013		
#	DEFICIENCY STATEMENT	FOLLOW-UP SURVEY STATUS
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)	Corrected
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)	Corrected
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)	Not Corrected
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)	Not Corrected

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

Section I 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).

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)(2) requires "[e]ach plan have written quality assurance systems, policies, and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, and continuity of covered health care services as required by the [Knox-Keene] Act."

Rule 1300.67.2.2(d)(2)(A) states "a plan's quality assurance program shall address: Compliance monitoring policies and procedures ... designed to accurately measure the accessibility and availability of contracted providers, which shall include tracking and documenting network capacity and availability with respect to the standards set forth in [Rule 1300.67.2.2(c)]."

Brief Summary of Deficiency #1: In the March 6, 2013 Final Report, the Department made numerous factual findings concerning practices at the medical center or clinic level that were preventing the Plan from capturing and tracking information necessary to determine timely access to behavioral health services. Specifically, the Department identified the following issues:

- 1) Paper Wait Lists: When no appointment slots were available, clinics were using paper wait lists and not counting the days that enrollees remained on the list.
- 2) Changed Appointment Times: In situations where the enrollee's appointment was changed, the period measured was time between the canceled appointment and the new appointment.
- 3) Consultation Requests: Timely access tracking of appointments made based on a consultation request did not include the one or two days that elapsed while the clinic contacted the enrollee to book the appointment.
- 4) Overbooked Appointments: At least one medical center reported a timely access wait time of zero days when the enrollee was "overbooked" (put into an appointment with an expectation of an opening due to a no-show by another patient.)

The Final Report noted that the Plan needed to correct these specific practices and implement a process to disseminate all revised procedures, conduct remedial training for staff responsible for

scheduling appointments, and establish and implement an accurate process and system for tracking, measuring, and monitoring timely access.

Plan Compliance Efforts Following Issuance of the March 6, 2013 Final Report

SOUTHERN REGION

In response to Deficiency #1, the Plan assessed its data collection procedures, identified problems, met with medical center leaders regarding non-compliant practices, and developed corrective action plans.

Clerical staff and providers who book their own patients were required to undergo training, which was conducted from June to September 2013. Training focused on non-compliant practices (e.g., paper wait lists) and booking processes (e.g., handling rescheduled appointments, recording changes in providers, and using target dates). New staff members are now trained as they are hired, and are initially partnered with existing staff members until managers are comfortable with the performance of the new staff. Annual refresher training for all staff is conducted at each medical center, and training materials have been placed on an internal website for reference.

The Plan conducted validation audits to ensure that unacceptable practices were discontinued. The Plan's regional auditors reviewed appointment-booking processes, conducted interviews with booking staff and clinicians, examined the use of system codes, reviewed training materials, and validated completion of training through review of sign-in sheets. Regional auditors visited three sites/medical centers through April to May 2013 and provided feedback to those and other sites to guide corrective actions and revisions of training materials. The auditors visited three additional sites between July 2013 and September 2013. At the time of these visits, the Plan had not yet determined whether similar Plan-wide audits would be periodically performed in the future but noted that day-to-day oversight of staff performance and weekly/periodic audits of key data fields are the responsibility of local managers.

Based on the Plan's follow-up audits and oversight activities, Plan officers confirmed in interviews that paper wait lists have been discontinued¹ and that correct booking processes are being followed.

NORTHERN REGION

The Plan made programming and process changes to improve the accuracy of its appointment data in the Patient Appointment Registration Reporting System (PARRS). As noted in the March 6, 2013 Final Report, staff training on some issues occurred in 2012. As programming changes occurred, additional training was conducted. For example, training to clarify initiation dates was accomplished in April 2013, and training for e-consult in May 2013. When various database functions went live in August 2013, further training was conducted. Because some clinical staff make their own appointments, both clinical and clerical staff underwent training. New staff members receive training as part of orientation, and refresher training will be conducted annually.

¹ Electronic wait lists are still used. However, the Plan reports that its new methodology for timely access measures wait times from the date the patient requests the appointment until the date the patient is seen.

The Plan conducted audits in the Northern Region equivalent to those described above for the Southern Region. The Plan's initial audit in early 2013 detected the presence of some remaining issues that were described in the Department's Final Report² for the Routine Medical Survey concerning behavioral health services. For example, the Plan's internal audit report stated:

[N]ot all requests for initial appointments were recorded in the official appointment booking systems (e-consult and/or PARRS). Oakland and Fresno Medical Centers maintained an electronic off-system (excel worksheet and/or a walk-in form) to document new appointment requests (telephone and walk-in) and attempts made to contact the patient for an appointment. It was determined that reconciliations were not always performed to ensure that the initial requests for appointments were carried over to the official appointment booking system accurately. Consequently, these practices could impact the accuracy and completeness of the data used for tracking and reporting of the initial appointment request dates and actual member wait time.

Follow-up audits were conducted in August 2013 at three sites. Based on its follow-up audits and oversight activities, Plan staff confirmed that appointments can now be booked as far in advance as provider schedules are released, i.e., three to four months out, which helped to eliminate the perceived need for paper wait lists. The Plan reported that paper wait lists have been completely eliminated. The e-consult system is used (with PARRS as backup) to track the date of initial referrals for use in calculating wait times.

Department Actions to Verify Corrective Action: To confirm the Plan's internal assessment of data improvements, the Department audited the accuracy of data for 30 randomly selected patient medical records in the Northern Region and 15 randomly selected patient medical records in the Southern Region.³ The Department compared data on appointment request dates and dates when appointments actually occurred as recorded in patient medical records. These records were checked against dates from a summary listing generated from the Plan's data system. The comparison demonstrated that data contained in the database was accurate and consistent.⁴

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan has made significant system changes and conducted training to address data problems. The Plan performed audits to verify the effectiveness of its corrective actions. Based on interviews, review of documents and reports, file audits, and subsequent meetings with Plan representatives, the Department confirmed that data being recorded in the Plan's system appears to reflect accurate dates of appointment requests and occurrences. Therefore, the Department finds that this deficiency has been corrected.

² The Final Report was issued on March 6, 2013.

³ These records were identified as part of a sample of medical records used to assess the Plan's corrective action in connection with Deficiency #3.

⁴ This data was also used for calculation of the Plan's appointment wait times – see Deficiency #3.

Use of Externally-Contracted Providers

During the Follow-Up Survey, the Plan indicated that part of its strategy to increase the number of available providers involves the delivery of services by providers who are external to The Permanente Medical Group (TPMG) and the Southern California Permanente Medical Group (SCPMG). As of October 2013, the Plan indicated that, at five Southern Region medical centers that most heavily rely on the use of externally-contracted providers, less than 10% of patients are seen by such providers. The Plan also indicated that, at that time, other medical centers in the Southern Region use externally-contracted providers much less frequently.

With respect to the Northern Region, the Plan indicated that its use of externally-contracted providers through ValueOptions (a Knox-Keene Act-licensed plan that contracts with Kaiser to deliver behavioral health services through a network of contracted providers) grew significantly during 2014. However, the Plan was unable to provide the Department with detailed data identifying the percentage of enrollees in both regions who have been referred to externally-contracted providers.

The timely access regulation does not expressly distinguish between internally-contracted and externally-contracted providers. Rule 1300.67.2.2(d) does, however, require health plan quality assurance systems to ensure that the Plan's provider network provides accessibility and availability of services and to implement prompt investigation and corrective action when compliance monitoring indicates that the network is not sufficient to ensure timely access.

Although Kaiser's externally-contracted providers do not currently have full access to the Plan's electronic medical records and appointment systems, documentation related to quality assurance procedures currently in place indicates that the Plan monitors access to these providers through ongoing review of claims and referrals. With respect to the use of the ValueOptions network in the Northern Region, the Plan confirms that formal timely access monitoring by the Plan (pursuant to the Plan's revised timely access methodology) began in August 2014.

The Department will conduct further compliance review of the Plan's policies, procedures and implementation of formal timely access tracking and monitoring of externally-contracted providers during its next Routine Survey.

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. Subsection (d)(2)(A) requires these procedures include tracking and documenting network capacity and availability with respect to the standards set forth in Rule 1300.67.2.2(c).

Brief Summary of Deficiency #2: In the March 6, 2013 Final Report, the Department found that the Plan's methodology for calculating compliance with timely access standards and appointment timeframes did not comply with applicable provisions of the Knox-Keene Act. Among other concerns, the Department noted that the Plan's reliance on a methodology that averaged all reported enrollee wait times for a given month failed to account for each individual enrollee's wait time and therefore could obscure excessive wait times by averaging them with shorter wait times. Such an approach could prevent effective treatment of an enrollee's condition or fail to prevent further deterioration of an enrollee's health.

The Final Report noted that the Plan needed to establish monitoring systems and processes sufficient to ensure that enrollees receive appointments within the regulatory standards set forth in Rule 1300.67.2.2. These monitoring systems and processes must also allow the Plan to identify trends and patterns of excessive wait times, so that appropriate corrective action can be taken.

Plan Compliance Efforts Following Issuance of the March 6, 2013 Final Report

The Plan reported that it strengthened its oversight mechanisms for access by revising its methodology, establishing two new access committees, developing new reports, and in some cases, implementing corrective actions within its contracted medical centers.

- 1) *New Methodology* - In both regions, the Plan adopted a new measure for tracking access to appointments called "Percentage Initiated to Seen," also referred to as "Appointments within Standard."⁵ The new measure reports, by Plan department and Plan facility, the percentage of initial appointments with wait times that fell within the timeframe applicable to each appointment type set forth in Rule 1300.67.2.2(c)(5). This new measure differs from the previously used "Average Days Wait" because it shows the percentage of appointments in which the wait time fell within the applicable period,

⁵ The "Percentage Initiated-to-Seen" also known as "Appointments within Standards" measures wait time from the date of the request for an appointment to the date the member is actually seen (rather than to the date of the first available or offered appointment.) Recognizing that patient choice may result in some appointments exceeding the timeframe, the Plan set its threshold for corrective action for any medical center that falls below 80% of initial appointments occurring within standards. However, the Plan also reports that it takes action prior to any medical center falling below 80%, if a substantial drop occurs from one month to the next.

- 2) rather than an **average** of all wait times over a month. The Plan filed its revised methodology through an amendment submitted to the Department and initiated reporting under its new methodology.

- 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 copies of the charter for each of these access committees. Three access reports (Percentage Initiated to Seen, Ratio of Providers to Members and Average Days Wait) associated with behavioral health are regularly reviewed by each of the access committees. Plan officers are accountable for monitoring access and ensuring any corrective action when warranted.

Plan officers also 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 actions by individual behavioral health departments to remediate access compliance issues; and
- Report issues and actions to the appropriate Access Committee.

Further, Plan officers are responsible to ensure that actions taken at a local level are aligned with actions taken by the respective regional Access Committees. Each Area Manager and Executive Director collaborates with the Area Medical Director or Physician in Chief to consider member grievances and concerns related to access issues, and to ensure appropriate responses and actions are developed when these issues are raised by members.

On a quarterly basis, beginning in late 2012, both regional Access Sub-Committees began reporting on access to their applicable regional Quality Committee. In the event that either committee identifies issues that warrant more frequent attention, the committee may escalate the issue (outside of the regular report cycle) to the applicable regional Quality Committee.

The Plan explained that its Regional Quality Program Descriptions and Work Plans were updated in April 2013 to include activities undertaken by its new Access Committees in Northern California and Southern California.

The Plan has incorporated its new “Percentage Initiated to Seen” measure into its Rate of Compliance methodology for annual submissions to the Department concerning compliance with the Timely Access Regulation. The weight given to each measure in the Rate of Compliance has been revised in order to incorporate this new measure and give substantial emphasis on individual enrollee wait times as follows:

- Percentage Initiated to Seen/Appointments Within Standard Rate: 50%
- Provider Survey Average Rate: 20%
- Access Complaints Rate: 20%
- Average Days Wait Rate: 10%

Department Actions to Verify Corrective Action: To assess improvements in the appropriateness and accuracy of the Plan's timely access methodology, the Department conducted interviews with Plan information technology staff in both the Northern and Southern regions during the Follow-Up Survey. The Department also reviewed both regions' Statistical Analysis System programming code to verify that:

- Rates were correctly calculated;
- Appointment types/categories were included and excluded, as appropriate;
- Calculations were correctly performed;
- Patient and staff cancellations were calculated correctly;
- Rescheduled visits used the correct starting date;
- Changes in assigned providers were considered appropriately; and
- Physician and non-physician services were appropriately distinguished.

To conduct ongoing monitoring of the availability of behavioral health appointments, the Plan now uses the new measure in addition to other measures such as member complaints, member surveys, provider surveys, geo-access reporting, telephone wait time statistics and average days wait. New monthly and quarterly monitoring reports using the measure have been designed and implemented in both the Northern and Southern Regions. The Department confirmed through interviews and review of committee minutes that these reports are regularly reviewed by Plan staff, leadership teams, and medical center/regional quality and access committees.⁶

The Plan filed its revised methodology through an amendment with the Department and initiated reporting under the new methodology.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan created a new measure for tracking and reporting appointment wait times, developed reports that identify this data by Plan medical center and department, and uses the reports for ongoing monitoring and reporting of its compliance with timely access. Therefore, the Department has determined that this deficiency has been corrected.

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.

⁶ See Deficiency #3 for additional information on monitoring/use of resulting data.

Rule 1300.70(b)(1)(D) requires a 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) provides that 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 Quality Assurance activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated Quality Assurance responsibilities.

Rule 1300.67.2.2(d)(3) requires each health plan to promptly investigate and initiate corrective action in any situation where the plan's monitoring of timely access compliance reveals that the plan's provider network is not sufficient to ensure compliance with the timely access standards.

Rules 1300.67.2.2(c)(1) and (5) described in Deficiency #2 also apply. These rules require plans to provide timely care within certain specified timeframes.

Brief Summary of Deficiency #3: In the March 6, 2013 Final Report, the Department noted that the Plan, its medical groups, and its medical centers identified access deficiencies regarding non-compliant appointment wait times but either failed to resolve the deficiencies or did not resolve the deficiencies until several months after they were identified. As a result, the Department concluded that the Plan did not ensure that its Quality Assurance Program, its medical groups, and its medical centers were taking effective action to improve care where deficiencies were identified, as required under Rule 1300.70.

The Final Report identified three areas for the Plan to improve:

- 1) The Plan, its medical groups, its medical centers, and any Plan-delegated quality assurance functions must promptly establish and implement corrective actions to resolve systemic access deficiencies identified by the Department and the Plan.
- 2) The Plan should establish and implement a process to ensure that it monitors and oversees its medical groups and medical centers so that prompt and effective action is taken to improve care where deficiencies are identified.
- 3) The Plan should establish effective ongoing oversight procedures to ensure that providers fulfill all delegated quality assurance responsibilities.

Plan Compliance Efforts Following Issuance of the March 6, 2013 Final Report

In response to this deficiency, the Plan submitted a corrective action plan committing to the following actions in each region:

- 1) **New Measurement Methodology** - The Plan adopted a new measure for tracking access to appointments.⁷ The Plan filed an amendment with the Department's Office of Plan Licensing regarding its new methodology for measuring and tracking access and

⁷ See Percentage Initiated to Seen described in Deficiency #2.

implemented tracking reports that include the measure.⁸ The Plan's new measure captures the number of days between the enrollee's request for an appointment and the date upon which the enrollee was actually seen by the provider.

- 2) **New Committees** - The Plan formed new committees specifically dedicated to monitoring and ensuring access in each region. The committees are responsible for monitoring access for all clinical departments/specialties, including behavioral health services. Higher-level regional oversight occurs as the committees report up to their respective regional quality committees.
- 3) **Implementation and Monitoring of Department-Level Specific Corrective Action Plans** - The new access and ongoing regional quality committees, Plan leadership, medical center leadership, and medical group leadership regularly review timely access performance reports, require corrective action plans, and track improvements resulting from those corrective actions.

As part of its corrective action, the Plan provided the Department with details concerning additional changes made by the Plan to address this deficiency. These changes, which differ between the Northern Region and the Southern Region, are described in the assessment below.

Assessment of the Effectiveness of the Plan's Follow-Up Compliance Efforts

In order to assess the Plan's correction of Deficiency #3, the Department took the following steps within the scope of the Follow-Up Survey:

1. **Review of Minutes:** The Department reviewed minutes from the new committees that were formed to monitor and ensure access in each region.
2. **Review of Plan-Generated Access Reports:** The Department reviewed medical center-specific reports generated by the Plan under its new measure for tracking timely access to appointments (as noted above, the Plan's new approach tracks elapsed time between the request for an appointment and the time at which the patient is actually seen.)
3. **Medical Record Review:** The Department reviewed a random sample of 297 medical record files for patients seeking services for mental health conditions. This review included assessment as to whether each patient received timely access for his or her initial appointment as well as any necessary follow-up appointments.

⁸ The Final Report cited the Plan's Timely Access Monitoring measure, its 80% Timely Access Reporting standard for "Percentage Initiated to Seen" and the 80% threshold for implementation of a corrective action as non-compliant. The Department subsequently implemented its own industry-wide Timely Access Report Improvement Project and provided further guidance regarding the tracking of appointment data. The Plan filed its revised timely access reporting methodology through an amendment submitted to the Department. As noted in Deficiency #2, the Plan's filed amendment includes a revised methodology that measures the time elapsed from the date of request of the appointment to the date the appointment occurs and includes an aggregate measurement of four weighted metrics that form the basis for its annual report regarding timely access compliance. The amendment filed by the Plan indicated that it will measure against a 90% aggregate measurement to determine whether it had a satisfactory annual rate of compliance.

4. **Department Meetings with Plan Representatives:** The Department met with representatives of the Plan on several occasions to discuss changes that were effectuated in connection with implementation of corrective action, and to better understand the manner in which the Plan now responds to situations involving timely access deficiencies.

Review of Minutes

SOUTHERN REGION

The Southern California Access Sub-Committee (“Access Sub-Committee”) was formed in August 2012 as a sub-committee of the Member Concerns Committee, which in turn reports to the Southern California Quality Committee (“SCQC”). The Plan provided a copy of the Access Sub-Committee’s charter, updated Regional Quality Program Descriptions, and Work Plans to document its formation and activities.

The Access Sub-Committee meets monthly to review timely access data for all health care services covered by the Plan, including behavioral health services, and oversees needed corrective actions. The Assistant Executive Medical Director of the SCPMG and the Health Plan Executive Director for Quality/Risk/Regulatory/Safety serve as Co-Chairs. Representatives from the Plan include the Director of Health Plan Regulatory Services, the Managing Director for Quality and Regulatory Services, a Nurse Consultant, and the Vice President/General Counsel. Representatives from the SCPMG include the Executive Director, Medical Directors for various specialty areas, the Medical Group Administrator for Access, the Medical Group Coordinator for Access, the Regional Autism Coordinator, a Regional Associate Medical Group Administrator for Behavioral Health Care Services and other access staff and a consultant. The Plan indicated that three members of the committee have experience in the delivery of behavioral health care services.

SCPMG personnel and department representatives from specialty areas, including behavioral health, attend the Access Sub-Committee meetings depending on the agenda and whether information or corrective action plans are required from their respective areas.

Meeting minutes reflect that the Access Sub-Committee, which meets most months, regularly reviews reports on percent of appointments booked within standard, appointment volume, staffing levels, grievance rates, satisfaction surveys, and other related matters. The Access Sub-Committee began reviewing performance data and action plans based on “Average Days Wait” in August 2012 and the new measurement, “Appointments Within Standard” in December 2012. The report shows compliance rates for urgent and non-urgent appointments for each of the 13 medical centers and for the region by specialty department. Behavioral health statistics are broken down between psychiatrists and non-physicians.⁹

Meeting minutes also indicate that the Access Sub-Committee requires corrective action plans for any medical centers with individual departments falling outside of compliance. The status and effectiveness of each action plan for each medical center are tracked at

⁹ Non-Physicians include allied healthcare professionals, such as licensed clinical social workers, marriage and family therapists, and psychologists.

every meeting.¹⁰ Corrective action planning and progress reporting are detailed. For example, they include the number of new appointments expected for each new hire and added day of staff time. Corrective actions include hiring staff, working additional hours or days, extending clinic hours, borrowing staff from other Plan medical centers, overbooking in situations where patient cancellations are a problem, correcting booking category errors, using registry providers, and using externally contracted providers. If significant problems occur or problems are not resolved in a reasonable period of time, the minutes indicate the problems are escalated to the Plan/Regional Health Plan Officers and the SCQC.

The Access Sub-Committee reports quarterly to the Member Concerns Committee and the SCQC. Reports include detailed updates on medical centers that are on corrective action plans and review wait time reports broken down by medical center and specialty department. Medical center leadership also report in-person directly to the SCQC in rotation—each reporting twice per year, or more frequently if needed, and access issues are a key topic of discussion.

NORTHERN REGION

As in the Southern Region, the Plan formed the Northern California Access Committee (“Access Committee”) in July 2012 to focus on oversight of access issues. It reports directly to the Quality Oversight Committee. The Plan provided a copy of the Access Committee’s charter, updated Regional Quality Program Descriptions, and Work Plans to document its formation and activities.

The Access Committee meets monthly to review timely access data for all health care services covered by the Plan, including behavioral health services, and oversees needed corrective actions. The Plan’s Vice President of Quality and Regulatory Services and the Associate Executive Director of TPMG serve as Co-Chairs. Representatives from the Plan include the Vice President of Regulatory Services, the Strategic Leader of Regional Health Plan Quality, Accreditation and Regulation, Executive Director of Quality and Regulatory Services, the Vice President of Hospital and Health Plan Area Operations, and the Plan Vice President/Regional Counsel. Representatives from the TPMG include an Associate Executive Director, the Area Executive Director for Health and Mental Health, the Chiefs Group Liaison, and the Director of Quality and Operations Support.

TPMG personnel and department representatives from specialty areas, including behavioral health, attend the Access Committee meetings based on the agenda and whether information or corrective action plans are required from their respective areas.

The Access Committee receives and reviews reports of the new measure for urgent and non-urgent appointments by medical center and by individual specialty department, including behavioral health. The Access Committee also reviews related data, such as average days wait, provider-to-member ratios, enrollee and provider satisfaction survey results, and access-related grievances. Similar reports are provided on a more frequent basis (e.g., weekly) to Plan and medical center physician leaders and administrators. If any department is out of compliance

¹⁰ The Plan indicated that the status and effectiveness is also reviewed outside this sub-committee daily/weekly by department staff, medical centers, and Plan/SCPMG management.

(below 80%) for one month, the Access Committee contacts the department leaders for details and to assess corrective actions. If the concern cannot be immediately corrected, the physician-in-chief and area manager must attend the next meeting and present a corrective action plan.

The meeting minutes indicate that the committee tracks and reviews corrective action plans at each meeting, updates the plans when necessary, and discusses progress with the involved medical centers/departments. The action plans are detailed (e.g., specifying number of staff to be added, number of additional appointments created, implementation dates, etc.). The following are examples of the types of corrective actions implemented and their results:

- Psychiatry at Napa-Solano Medical Center for January of 2013: 75% of appointments were within the Plan's wait time standards. In February, March, and April the rate dropped to 64%, 55%, and 51%, respectively. In May, it rose to 76%. The Plan began video and telephone appointments, utilized a psychiatrist from another medical center, increased clinic hours, recruited new staff, and utilized use of other staff temporarily to fulfill the duties. For the remainder of the year, the rate was above 90% with 100% compliance in December.
- Psychiatry at South Sacramento Medical Center for January of 2013: 53% of appointments occurred within the Plan's wait time standards. The Plan identified a root cause of the problem involving a need for child psychiatry and arranged for sharing of resources with other area facilities. The rate rose to 84% in February and 91% in March. It dipped to 82% in April and rose to 93% or above for the remainder of the year.

Access Committee meeting minutes, including wait time reports, are submitted to the Quality Oversight Committee, where they are reviewed quarterly. Data is also shared with medical center and regional leadership. The Department's review of the reports found that downward trends in compliance rates are being detected and corrective action plans are implemented.

Based on interviews and review of committee minutes, policies, reports, and additional relevant documents, the Department confirmed that the Plan has undertaken extensive committee-based corrective actions, including the implementation of improved reporting measures and corresponding reports, the establishment of committees focused on access, improved intensity of oversight, and accelerated implementation of corrective action plans in response to access concerns.

The Department notes that the Plan's amendment reflecting the changes to its monitoring policies and procedures is not complete, pursuant to Section 1352 and Rules 1300.67.2.2(g)(1), 1300.67.2.2(d), 1300.70(b)(2)(A), 1300.51(J)(2)-(3) and 1300.52. The Department directs the Plan to file an amendment documenting its process for oversight using the "80% or significant drop" metric for initiating inquiries to its provider groups.

Review of Plan-Generated Access Reports

Rule 1300.70 requires that each plan's Quality Assurance Program document that "effective action is taken to improve care where deficiencies are identified." To evaluate whether the

Plan's increased monitoring and corrective actions were effective in ensuring that behavioral health appointments are offered within the regulatory timeframes, the Department reviewed results from Plan-generated access reports.

At the time of the 2012 Routine Medical Survey, the Plan's methodology in both regions for reporting compliance based on averaging wait times did not present a complete picture of wait times. That methodology could offset long wait times with shorter wait times by using averages, which allowed monthly wait times at a number of the medical centers to be reported as compliant even though a significant proportion of the appointments exceeded the standard.¹¹ Moreover, the Northern Region's data was too unreliable to draw firm conclusions about timeliness.^{12 13} However, the Plan identified several medical centers with high proportions of non-compliant appointment wait times that remained non-compliant over multiple quarters with no improvement.

The flawed data hindered the Department from making a full assessment of Plan performance during the previous Routine Medical Survey. Given that the new measure now provides a more useful picture of wait times for initial appointments,¹⁴ the Department re-visited both regions to review the data from January 2013 to December 2013, and to assess the effectiveness of the Plan's monitoring and corrective actions. The Plan's reports showed:

SOUTHERN REGION

There was an improvement in the percent of initial appointments booked within standard during 2013. Compliance rates for psychiatrists' initial appointments occurring within 15 days of the request were 90% or higher at all medical centers by August. All but one¹⁵ had been above 80% for three consecutive months. Non-physician compliance rates for August showed one medical center at 80% compliance for initial appointments occurring within 10 days of the request, one at 85%, and all others at 90% or above. All but one medical center¹⁶ had been above 80% for at least three consecutive months.

NORTHERN REGION

In January 2013, psychiatry appointments at five medical centers¹⁷ were below 80% compliance (53%, 58%, 75%, 76%, and 78%) for initial appointments within 15 days. Non-physician appointments at four medical centers¹⁸ were below 80% compliance (47%, 59%, 69%, and 75%) for initial appointments occurring within

¹¹ See Deficiency #2 for further information.

¹² See Deficiency #1 for further information.

¹³ The Southern Region uses a different data system than the Northern Region; several of the issues noted in Deficiency #1 were seen in the Northern Region but not in the Southern Region (e.g., failure to retain an accurate history of booking dates in order to accurately calculate wait times when appointments were changed). Data for the South was more accurate than data for the North.

¹⁴ The Plan's reports with the new measure, Appointments Within Standard, track appointment wait time for initial visits only. These reports do not include wait times for follow-up visits. Patients who are out of treatment for a significant period of time (e.g., six months) or beginning a different type of care/provider may be viewed as having a new episode of care and tracked as having an initial appointment for that episode.

¹⁵ Woodland Hills Medical Center

¹⁶ Downey Medical Center

¹⁷ South Sacramento, Redwood, Napa Solano, Central Valley, and San Francisco

¹⁸ Santa Rosa, East Bay, Redwood, and South Sacramento

10 days of the request. Plan reports show that all of these departments were brought above 80% compliance (most above 90%) by late 2013.

The Plan's results indicate that low compliance rates for initial appointments have improved in some medical centers. However, this data and subsequent 2014 access reports reviewed revealed that access compliance rates for both psychiatrist and non-physician appointments continue to be volatile at some medical centers in both regions.¹⁹

Medical Record Review

The Department reviewed a random sample of 297 patient medical records selected from enrollees who had an initial visit within specified timeframes from each of nine medical centers.^{20 21} In the Southern Region, 149 cases were reviewed.²² In the Northern Region 148 cases were reviewed.²³ Using the same sample, the Department also validated information on follow-up appointments.

Review of the medical records²⁴ assessed the following:

- **Timely access to an initial appointment** was measured against the requirements of Rule 1300.67.2.2(c)(5)(A), (D) and (E).²⁵ Under this standard, non-urgent initial appointments with a non-physician mental health care provider must be available within 10 business

¹⁹ See Section titled "Department Meetings with Plan Representatives."

²⁰ The Department reviewed medical records from appointments occurring during the following timeframes: September 10-14, 2012, December 10-14, 2012, March 11-15, 2013, June 9-13, 2013, and September 16-20, 2013.

²¹ The Department's file review team consisted of two physicians, five registered nurses, and four licensed clinical psychologists. All reviewers have active licenses to practice in the State of California and experience in various clinical areas, including medical-surgical care, pediatrics, and mental health care. Both physicians and two of the registered nurses are managed care experts and regulatory reviewers. The review team was supplemented by a psychiatrist and a clinical psychologist who are both behavioral health managed care experts; they served as consultants on managed care, integrated health care delivery system, complex cases and community professional standards. Database management and analysis were performed by a research methodologist and an epidemiologist.

²² 30 cases from each of four Southern Region medical centers were selected. However, 29 cases were reviewed from a fifth medical center as one case was excluded because it did not meet review parameters.

²³ 25 cases from five medical centers were selected for review. However, 23 cases were reviewed from a sixth medical center as two cases were excluded, as they did not meet review parameters.

²⁴ The Department's file review team reported that a number of the patient medical records maintained by the Plan providers were inadequately documented. It was often unclear whether an appointment was available or whether the clinic's scheduler and/or therapists did not attempt to set an appointment. In some cases, poor, sparse, or cryptic clinical documentation of treatment plans and progress notes made it difficult to determine whether the Plan provider or the patient was responsible for initiating/following through on scheduling appointments. As a result, it was difficult to differentiate between appointment availability and lack of clinical follow-up. Reviewers also frequently encountered information gaps in patient histories, encounter dates, treatment dates, and clinicians/therapists' notes regarding patient treatment plans and progress. Where the Department's reviewers felt that Plan staff clinicians could clarify the details of treatment to determine whether access issues existed, meetings were arranged with Plan medical directors/staff to obtain additional information to fill in information gaps from the medical records.

²⁵ The Plan's policy, *Oversight & Monitoring for Access and Availability*, (Filing# 20140964, revised 4/30/14 for both the Northern and Southern Regions) sets forth timeframes consistent with the regulatory standards: "Urgent appointment offered within 48 hours; Non-urgent appointment for primary care offered within 10 business days; Non-urgent appointment for specialist offered within 15 business days; and Non-urgent appointment for non-MD mental health offered within 10 business days."

days of request, non-urgent appointments with a psychiatrist must be available within 15 business days of request, and urgent appointments with a psychiatrist or non-physician provider that do not require prior-authorization must be available within 48 hours.

- **Timely access to follow-up appointments** was measured against Rule 1300.67.2.2(c)(5)(A), (D) and (E) or, where applicable, Rule 1300.67.2.2(c)(5)(H) which allows, “[P]eriodic follow-up care, including ... *periodic office visits to monitor and treat ... mental health conditions ...* [to] be scheduled *in advance* consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.” [Emphasis added.] Accordingly, records reviewed concerning follow-up appointments were measured against the treatment plan developed by the initial intake therapist and/or treating therapist(s) with consideration for changes in patient status and Department reviewer professional judgment.²⁶

The Department developed a data collection evaluation tool comprised of 93 items that covered basic patient information, such as age, gender, primary language spoken; summary of presenting symptoms along with initial and subsequent medical diagnoses; date(s) the patient contacted the Plan for appointment(s); date(s) of initial and follow-up appointments; information on cancellations when they occurred; type of provider(s) seen; treatment approaches planned; whether related inpatient or emergency room admissions occurred; number of individual and group appointments attended/missed; and whether sufficient documentation existed to complete the review.

SUMMARY OF MEDICAL RECORD REVIEW FINDINGS

	Category	Northern Region	Southern Region
1	Combined Appointment Wait Times - Enrollee did not have timely access to either an initial appointment or a follow-up appointment. ²⁷	33/148 (22%)	14/149 (9%)
2	Initial appointment for mental health services was not scheduled or did not occur within the required regulatory timeframe. ²⁸	13/148 (9%)	6/149 (4%)
3	Follow-up appointment for mental health services was not scheduled or did not occur within the required regulatory timeframe. ²⁹	26/148 (18%)	10/149 (7%)

²⁶ By the third visit or sooner, Plan staff clinicians should have developed a treatment plan tailored to the patient’s needs. The treatment plan would include frequency/intervals between sessions; types/levels of treatment (e.g., individual therapy; group therapy, including specification of group focus/topic; medication; substance abuse treatment), and measurable goals. The treatment plan may be modified over time to address factors such as improvements in the patient’s condition, increases in situational stressors, family crises, efficacy/side effects of medications, or identification of additional issues.

²⁷ In calculating the combined appointment wait time totals in Category 1, patients were not counted twice if they experienced delays in both initial and follow-up appointments. As a result, the totals in Categories 2 and 3 are not equal to the total in Category 1.

²⁸ The Plan’s new measure (described above) assesses the time elapsed between the date of the request for an appointment and the date upon which the appointment occurred.

The results of the Department’s Medical Record Review for initial and follow-up appointments are reflected in the following section. The results have been divided into the three primary categories identified on the preceding chart and are reported separately for the Northern Region and the Southern Region. In addition, summaries of some individual cases involving non-compliance with timely access standards are included.

1. Combined Appointment Wait Time Compliance – Initial and Follow-Up

Rationale and criteria: The Department analyzed data to assess the total number of cases where either the initial or follow-up appointment (or both) occurred within the regulatory timeframes. Patients who did not receive access to timely care at both their initial and follow-up appointments were counted as only one instance of non-compliance in this analysis.

Rules 1300.67.2.2(c)(A), (D) and (E) require that urgent behavioral health appointments not requiring preauthorization be available within 48-hours. Non-urgent (routine) appointments with psychiatrists must be available within 15 business days and appointments with non-physician staff must be available within 10 business days. Rule 1300.67.2.2(c)(5)(G) allows follow-up appointments, scheduled in advance, to occur within professional recognized standards of practice as determined by the treating licensed health care provider.

NORTHERN REGION

In the Northern Region, the Department identified 33 of 148 cases (22%) that demonstrated lack of timeliness for the initial appointments and/or lack of timeliness for follow-up appointments.

Northern Region Timely Access to Initial and/or Follow-Up Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
Z	25	20 (80%)	5 (20%)
D	25	21 (84%)	4 (16%)
Q	25	17 (68%)	8 (32%)
F	25	21 (84%)	4 (16%)
U	23	18 (78%)	5 (22%)
S	25	18 (72%)	7 (28%)
TOTALS	148	115 (78%)	33 (22%)

²⁹ Rule 1300.67.2.2(c)(5)(G) allows a follow-up appointment scheduled in advance to occur within professional recognized standards of practice as determined by the treating licensed health care provider; to the extent that this did not occur, the timeliness of the follow-up appointment was measured per the applicable regulatory timeframes found in the Timely Access Regulation, including Rule 1300.67.2.2(c)(5)(E) - 10 days for an appointment with a non-physician mental health provider, and Rule 1300.67.2.2(c)(5)(D) - 15 business days for an appointment with a specialist physician.

SOUTHERN REGION

In the Southern Region, the Department identified 14 of 149 cases (9%) that demonstrated lack of timeliness for the initial appointments and/or lack of timeliness for follow-up appointments.

Southern Region Timely Access to Initial and/or Follow-Up Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
W	30	26 (87%)	4 (13%)
Y	30	30 (100%)	0 (0%)
A	29	25 (86%)	4 (14%)
K	30	27 (90%)	3 (10%)
X	30	27 (90%)	3 (10%)
TOTALS	149	135 (91%)	14 (9%)

2. Initial Appointment Timeliness

Rationale and criteria: Rules 1300.67.2.2(c)(A), (D) and (E) requires that urgent behavioral health appointments not requiring preauthorization be available within 48 hours. Non-urgent (routine) appointments with psychiatrists must be available within 15 business days and appointments with non-physician staff must be available within 10 business days.

NORTHERN REGION

The Department identified 13 of 148 cases (9%) in the Northern Region that exceeded the timely access standards for initial appointments. Wait times that exceeded the standard ranged from 18 to 41 calendar days.

Case Examples of Delays in Access to Care:

- **Case #J23:** A teenager was referred for year-long symptoms of depression, including suicidal ideation. The patient waited 24 calendar days for the initial appointment. Additional details of this case are provided in the case example noted in the follow-up appointments section.
- **Case #B19:** The therapist documented the patient was referred for an urgent crisis appointment due to suicidal ideation. The patient, diagnosed with major depression, had to wait *five calendar days* for an appointment, instead the 48 hour mandated standard.
- **Case #B4:** The patient presented in the emergency room as having significant auditory hallucinations, agitated, feeling as though having a "nervous breakdown." Patient reportedly had taken six Adderall—a psychostimulant. Symptoms included increased heart rate and panic. Email communication to the Plan's behavioral health department from a Plan ER physician stated, "Your pt. was seen in ER today, needs urgent f/u." A Plan staff RN called the patient the following day and instructed the patient to stop

Adderall and Prozac until instructed otherwise. The follow-up appointment was scheduled for *four calendar days* later, not within 48 hours as required by Rule 1300.67.2.2(c)(A).

Northern Region Timely Access to Initial Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
Z	25	23 (92%)	2 (8%)
D	25	25 (100%)	0 (0%)
Q	25	21 (84%)	4 (16%)
F	25	21 (84%)	4 (16%)
U	23	20 (87%)	3 (13%)
S	25	25 (100%)	0 (0%)
TOTALS	148	135 (91%)	13 (9%)

SOUTHERN REGION

In the Southern Region, the Department identified 6 of 149 cases (4%) that exceeded the timely access standards for initial appointments.

The longest wait occurred in Case #R13, where the enrollee’s request for an initial appointment resulted in *an appointment scheduled 37 calendar days later*. Medical Record Review and discussion of the case with Plan staff did not uncover a reason for this very significant delay. The remaining four routine cases were all seen beyond the 10-day regulatory standard but within 27 calendar days of the initial request. The remaining urgent case (Case #P27, a patient with suicidal ideation but without a plan) was seen within *16 calendar days*, despite the 48-hour mandated standard.

Southern Region Timely Access to Initial Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
W	30	29 (97%)	1 (3%)
Y	30	30 (100%)	0 (0%)
A	29	25 (86%)	4 (14%)
K	30	29 (97%)	1 (3%)
X	30	30 (100%)	0 (0%)
TOTALS	149	143 (96%)	6 (4%)

3. Follow-up Appointment Timeliness

Rationale and criteria: Rule 1300.67.2.2(c)(5)(A)-(B) and (D)-(E) set timeframes for initial behavioral health visits. These standards may also be applicable to follow-up visits in some circumstances. However, Rule 1300.67.2.2(c)(5)(H) provides that “periodic follow up care, including ... *periodic office visits to monitor and treat ... mental health conditions ... may be scheduled in advance* consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.” [Emphasis added.]

Follow-up appointment access was assessed case-by-case based on the treatment plan/scheduling determinations of the intake clinician and treating providers, on the regulatory requirements noted above, and on patient need consistent with professionally recognized standards of practice. In many cases Plan providers documented inadequate treatment plans. Frequency, interval, and duration of recommended treatment modality (e.g., individual psychotherapy) were often absent and recommended return visits were often vague.

NORTHERN REGION

The Department identified 26 out of 148 cases (18%) in which there were significant delays in timeliness of follow-up appointments. Relevant case examples include:

- **Case #J23:** An immigrant teenager, whose primary language is not English, reported rapid weight loss since arrival to the U.S.A. as well as long-term symptoms of depression, including suicidal ideation. The patient was initially evaluated by a family therapist, who recommended family and individual therapies, and by a dietician working in an eating disorder program. The patient had transportation issues, so a transfer to a more convenient treatment location was requested. The dietician recommended one or two sessions with a therapist for risk assessment prior to transfer. *There was no evidence of an attempt to schedule a therapy visit or other treatment at either of the two locations, nor were interpreter services offered.*
- **Case #B23:** A sexual assault victim was initially seen by a Plan psychiatrist and diagnosed with post-traumatic stress disorder (PTSD) and major depression. An antidepressant was prescribed, but no follow-up appointment was scheduled. Numerous email exchanges between the patient and the psychiatrist evidence the patient’s difficulty in obtaining necessary Plan services in a timely manner. In one email, the patient requested referrals for individual psychotherapy and PTSD group therapy. *The psychiatrist responded by offering psychotherapy in the community at the patient’s expense and suggested that the patient investigate appropriate group therapy in the community because weekly individual therapy was not available in the Plan, and Plan group therapy did not address sexual assault.* Eventually, an appointment with a Plan therapist was scheduled five months after she was first seen.
- **Case #M12:** Large gaps in therapy over a 14-month treatment period were noted for a patient recognized as high risk for domestic abuse. The Plan provider attempted no outreach for missed appointments, and the visits did not follow the treatment plan, which included individual therapy, couple’s communication class, and couple’s therapy. Couple’s

therapy did not occur. Domestic abuse subsequently occurred resulting in severe injury. Thereafter, the patient requested an appointment with the treating psychiatrist but was unable to obtain one. The patient then changed psychiatrist and scheduled an appointment but cancelled it. Eventually, the patient saw a psychiatrist and was prescribed individual therapy and close monitoring and was directed to follow-up within three-to-four weeks. However, the follow-up appointment was scheduled months later and cancelled by the psychiatrist with no attempts to re-engage.

Northern Region Timely Access to Follow-Up Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
Z	25	22 (88%)	3 (12%)
D	25	21 (84%)	4 (16%)
Q	25	20 (80%)	5 (20%)
F	25	23 (92%)	2 (8%)
U	23	18 (78%)	5 (22%)
S	25	18 (72%)	7 (28%)
Average	148	122 (82%)	26 (18%)

SOUTHERN REGION

Ten of the 149 cases (7%) reviewed, were determined to exceed the applicable standard, under Rule 1300.67.2.2(c)(5) or other timeframe as indicated in the treatment plan or therapist notes (e.g., “return in 3 months for medication monitoring”) and consistent with professionally recognized standards of practice.

Despite the relatively low number of non-compliant files, the documentation in treatment notes suggests limited appointment availability and difficulty in obtaining follow-up appointments:

- **Case #P25:** A Plan therapist, who had already cancelled appointments with the patient on six separate occasions, stated in an email response to an established patient, "be sure to call and reschedule when you have a chance because *appointments are getting scarce again.*" [Emphasis added.]
- **Case #C20:** The therapist documented: "patient wants *regular ongoing treatment so may look outside Kaiser.*" [Emphasis added.]
- **Case #R21:** A child was brought in by her father due to the child’s aggressive behaviors, sexualized behaviors and significant behavioral problems in both the home and school environment. The family indicated they were in crisis and the child was referred for an evaluation by the therapist who completed the initial intake visit. However, the child was not seen for therapy *until seven weeks later.* The chart documented that the family pleaded for treatment, indicating that the child’s behavior and overall functioning were worsening. The evaluation occurred *eight calendar days* after the request falling well outside of the mandated timeframes for urgent appointments that should occur within 48

hours, due to acute symptoms. Further, no other treatment took place after the first therapy session, despite documentation in the chart of an urgent need for the treatment due to the child’s continued acute symptom pattern.

Southern Region Timely Access to Follow-Up Appointments			
MEDICAL CENTER	NUMBER OF FILES	COMPLIANT	DEFICIENT
W	30	26 (87%)	4 (13%)
Y	30	30 (100%)	0 (0%)
A	29	28 (97%)	1 (3%)
K	30	28 (93%)	2 (7%)
X	30	27 (90%)	3 (10%)
Average	149	139 (94%)	10 (7%)

Department Meetings with Plan Representatives

During 2014, the Division of Plan Surveys met with representatives of the Plan on several occasions. These meetings allowed the Department to gain a better understanding of the effect of the corrective actions undertaken by the Plan in connection with Deficiency #3 as well as additional challenges faced by the Plan in attempting to ensure timely access to behavioral health services.

During these meetings, the Plan provided the Department with detailed explanations regarding numerous operational issues that relate to or affect timely access to services, including but not limited to the following:

- The scheduling process for individual provider appointments in Plan medical clinics or departments;
- Steps that are taken at the medical clinic or department-level to try to accommodate increased appointment volume;
- The impact on access to care that can result from the departure of one or two clinicians or physicians from a single medical clinic or department;
- The steps that are taken to ensure that monthly access numbers return to 80% or higher, in situations where an individual medical clinic or department has a substantial drop in access, or dips below 80% in a given month;
- Activities undertaken by the Plan’s various access committees to identify and correct timely access issues;
- Corrective action plans that are designed and implemented within individual medical clinics or departments, including the process by which the clinic prepares an estimate of the number of appointment slots that will be needed in the future and implements corrective action (including the hiring of additional providers) to remedy access issues;
- Discussion regarding operational issues at various medical clinics and departments where access issues have been reported in the past;

- Review of monthly access reports for various medical clinics and departments in the Northern Region and the Southern Region;
- Discussion regarding steps undertaken by the Plan in situations where it wishes to refer enrollees to externally-contracted providers; and
- An explanation by the Plan regarding challenges presented in connection with the referral of enrollees to externally-contracted providers.

The information provided during these meetings was useful for the Department to understand challenges faced by the Plan when its Quality Assurance Program is required to take effective action to improve care, including timely access to services.

These meetings also confirmed that, between the issuance of the Final Report (March 6, 2013) and the Department-Plan meetings during 2014, the Plan made significant improvements to its Quality Assurance Program, particularly in the area of detection and follow-up on access to care issues at individual medical clinics or departments. It is clear that the Plan's new Access Committees are carefully and closely monitoring access issues, and reacting quickly in situations where issues arise within a medical clinic or department.

These meetings also included the Plan's description of significant labor-related challenges that it encounters when attempting to refer enrollees to externally-contracted behavioral health providers. Specifically, the Plan indicated that, prior to actually referring patients who need appointments with available externally-contracted providers (such as the ValueOptions network in the Northern Region); the Plan must first contact the union that represents the Plan's clinician providers to engage in a bargaining process. This process typically results in a significant delay before patient appointments can be booked with externally-contracted providers. Although it appears that this process has become more streamlined over time, the Plan's inability to immediately access care through these providers significantly hinders its attempts to take effective action to correct access and availability shortfalls at individual clinics or departments.

Despite the very significant strides made by the Plan in monitoring and assessing corrective action related to timely access to behavioral health services, the Plan's monthly access reports suggest that the Plan's current behavioral health provider network remains inadequate to serve the needs of its enrollee population. Further, in some areas, increased demand for patient appointments and/or provider departures can have a dramatic and immediate effect on enrollee access to care.

Examples of significant fluctuations in access to behavioral health care services include:

- A Northern Region medical clinic showed access figures for both psychiatrists and non-physicians dropped from the 90%+ to mid-50% within the course of three months during 2014. Figures remained in the 50% range until the Plan was able to successfully direct patients to externally-contracted providers (ValueOptions), but not until after the access figures had remained in the 50% range for a period of three months.
- In another Northern Region medical clinic, non-physician access figures for two months in 2014 were 91% for the first month and 63% for the following month.

- A third Northern Region medical center reported non-physician access figures from 92-98% over a six-month period. This medical center then dropped twenty-nine percentage points, from 92% to 63%, over a two-month period. This medical center continued to report access figures in the 60% range for three months in early 2014. Access figures rose but remained in the 70's range for five months, the Plan then began using externally-contracted providers (ValueOptions) at this center. Access figures then correspondingly rose between 91% to 100% in the months following this change.
- A fourth Northern Region medical center dropped 40 percentage points, from 96% to 56%, over a successive five-month period in 2014 in its psychiatrist access figures.
- In 2013, a Southern Region medical clinic reported non-physician access figures reported an increase in non-physician access figures of almost 40 percentage points, from 51% to 90%, within three months. In 2014, however, figures from this same clinic reflect a significant drop of 11% from 71% to 62% over a two-month period.
- In another Southern Region medical clinic, psychiatrist access figures show a 12-percentage point drop, from 75% to 63%, over a two-month period. In late 2014, access figures remained in the high 70's range and low 80's range for four months before dropping from 83% to 54%.
- A third Southern Region medical clinic reported a *50-percentage point drop*, from 92% to 42%, in its psychiatrist access figures over three successive months.

Data shared by the Plan for these and other medical clinics and departments confirmed access figures that strongly suggest a network that lacks the stability to ensure consistent timely access to behavioral health services. Despite the Plan's significant steps to monitor access issues, the Plan still encounters significant obstacles and barriers in quickly taking effective action to correct access deficiencies.

Follow-Up Report Deficiency Status: Not Corrected

As noted, the Plan filed its revised timely access reporting methodology to the Department and is regularly producing reports using its new methodology. Based on interviews with staff and review of committee minutes, reports, computer programs, policies, procedures, and other relevant documents, the Department verified that the Plan has designed and implemented an improved reporting measure that appropriately measures compliance with wait time standards.

The Plan also established new committees to focus on oversight of access performance and to facilitate prompt response to access concerns. Committee minutes now demonstrate the Plan's more rapid response in investigating problems and implementing corrective action plans. The Plan reports that it submits inquiries to the medical groups and reviews proposed corrective action submitted when the "Appointments within Standard" drops below 80% for a quarter, or when a significant drop occurs. However, the Plan has not filed an amendment with the Department regarding its revised quality assurance policies and procedures as required under Rule 1300.67.2.2(d) to include the 80% threshold it uses for internal monitoring of access.

Although patient medical record review shows that corrective actions have resulted in improvements in initial access to behavioral health services,³⁰ excessive waits occurred in follow-up appointments throughout the review period. In the Northern Region, 33 out of 148 (22%) patients seeking behavioral health services experienced a delay in access to care, either at the initial and/or follow-up appointment. Based on the Department's review of patient medical records, the Plan's efforts have not proven to be adequate and effective.

Meetings with the Plan throughout 2014 confirmed that the Plan took significant steps in monitoring and assessing corrective action related to access issues in individual medical clinics and departments; however, the Plan's own monthly access reports continue to show a lack of stability or a lack of available providers within the Plan's behavioral health provider network. This is compounded by the obstacles and barriers the Plan faces when trying to take effective action to correct access deficiencies.

Taken together, these issues present significant barriers to enrollees who need behavioral health services. The Plan must address the concerns discussed in this report and implement a process for regularly tracking availability and timeliness of follow-up appointments and taking effective and timely action when problems are identified.

The Department has determined that this deficiency remains uncorrected.

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 provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:

Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision, effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations 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.

³⁰ The Department's review showed seven of the 149 cases (5%) exceeded initial appointment standards in the Southern Region and thirteen of the 148 cases (9%) exceeded initial appointment standards in the Northern Region. These sample data correspond with the Plan's reports, showing these medical centers to be meeting compliance thresholds for initial appointments.

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.

Brief Summary of Deficiency #4: In the March 6, 2013 Final Report, the Department identified statements in certain enrollee informational materials that focused on coverage limitations and exclusions of mental health benefits while failing to identify that coverage must be provided for severe mental illness (SMI) or a serious emotional disturbances of a child (SED). Coverage of SMI and SED is the core of behavioral health services that are provided to all enrollees under California's mental health parity statute (Section 1374.72). In addition, some materials improperly stated that long-term individual therapy was not available to enrollees. The Department also found examples of member materials that, while literally consistent with the law, did not convey coverage in language that was likely to be understood by the average health plan member.

The Department noted that the inclusion of statements advising enrollees that medically necessary care for chronic conditions and long-term psychotherapy is not available to enrollees was in error because applicable health plan law requires the Plan to provide coverage for SMI and SED under the same terms and conditions as medical conditions. The Department also noted the Plan's obligations to provide health education to enrollees, including recommendations regarding the optimal use of services provided by the Plan or affiliated health care organizations. The Department concluded that materials in use by the Plan at that time included recommendations that might discourage enrollees from using certain health care services that are required to be covered under California's mental health parity statute.

The Final Report indicated that the Plan needed to take appropriate steps to ensure that (1) 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, (2) the materials do not mislead enrollees regarding the scope of coverage, and (3) the materials do not conflict with state or federal law. In addition, the Final Report noted that the Plan should conduct periodic audits of member materials published by its medical groups to prevent future misstatements of Plan benefits and also provide, on a proactive basis, effective health education services in the areas most affected by the inaccurate materials.

Plan Compliance Efforts Following Issuance of the March 6, 2013 Final Report

Plan staff shared the Department's concerns regarding Deficiency #4 with legal, behavioral health, and administrative staff in each medical center to begin corrective actions. The Plan began internal auditing procedures in April 2013. By the time of the Department's onsite Follow-Up Survey in the fall of 2013, the Plan had reviewed websites for all medical centers and hardcopy material (e.g., enrollee educational handouts) for three sample sites. Regional Plan auditors visited three sites during April and May of 2013 and three additional sites during July through September of 2013 to examine member educational material relating to benefits, visit limitations, etc. The Plan stated that its goal was to visit all medical centers by 2014.

The Plan's initial audit in early 2013 confirmed the presence of some of the issues described in the Department's Final Report. For example, the Plan's audit report dated April 2013 stated:

“Website – Outdated behavioral health information was found on the Santa Rosa and Fremont/Hayward websites. Potentially confusing behavioral health benefit information was found present on the Santa Rosa, Fremont/Hayward and Oakland/Richmond websites.”

SOUTHERN REGION

In follow-up, the Plan corrected specific documents that were found non-compliant by its auditors, conducted revisits where necessary, and reviewed new materials as they were developed. A policy requiring review and approval of new materials was developed and approved by the Southern California Quality Committee (SCQC) in May 2013.

In order to assess the effectiveness of the Plan’s efforts, the Department reviewed a selection of the Plan’s website documents and did not find any conflicting or confusing behavioral health benefit information.

NORTHERN REGION

In 2012, enrollee materials questioned by the Department were pulled from circulation. Beginning in May 2013, Plan staff worked with medical center quality leaders and medical group and clinic leaders to conduct inventories of all hardcopy materials given to patients. These materials were reviewed to assess any misleading/inaccurate statements relating to behavioral health benefits and to revise or eliminate any statements found to be misleading/inaccurate, as appropriate. The Plan visited each site to verify the completeness of inventories and the appropriateness of materials. Local websites underwent similar review to assess education and benefit-related postings.

The Quality Oversight Committee developed a policy to ensure that new materials undergo review prior to posting or distribution. The Plan indicated that it will conduct annual reviews in order to monitor compliance with its new policy.

As noted above, in order to assess the effectiveness of the Plan’s efforts, the Department reviewed a selection of the Plan’s website documents and did not find any conflicting or confusing behavioral health benefit information.

Inaccurate Provider Messages Identified During Medical Record Review

Although Plan representatives for both the Northern Region and the Southern Region stated in interviews that enrollees would be seen as often as medically necessary, the Department’s medical record review found that individual Plan providers/therapists did not consistently or effectively convey this message. To the contrary, messages conveyed to enrollees in certain cases indicated that access to behavioral health services is quite limited in scope. Information along the lines of what can be found in the case examples provided below can actively discourage patients from obtaining care. In addition, in situations where providers misunderstand the scope of benefits available to enrollees, they may fail to schedule patients for additional, medically necessary covered services.

- **Case #G2** revealed that the patient was told, “Longer term therapy is not a covered benefit under the Kaiser Health Plan. However, if you are interested in exploring this option, I can

provide you with suggestions for sliding scale clinics and private therapists in the community.”

- The treating psychiatrist in **Case #B23** wrote in an email to the patient, “No one ever sees a therapist once a week in the Kaiser Health Plan. Not a covered benefit for the past 20 something years and will not be a benefit in the future.”
- In **Case #C10** a father called two weeks after a cancellation to request another appointment. The clinician documented that it was explained to the father that appointments are scheduled on a “first come first served basis.” The patient and the father saw the clinician for a follow-up visit six weeks after the intake appointment.

Follow-Up Report Deficiency Status: Not Corrected

The Department finds that in response to concerns raised in the Final Report, the Plan implemented policies requiring review of materials prior to posting, conducted audits of website and hardcopy materials, and correcting misinformation, as necessary.

While substantial progress has been made to ensure the accuracy of website and hardcopy materials, *inaccurate and misleading behavioral health education information was disseminated verbally and in writing* to patients by providers in cases reviewed by the Department as part of its medical record review. The bold statements made by the Plan providers directly to enrollees regarding inaccurate limitations concerning the scope of their coverage for behavioral health services conveys a widespread misunderstanding of the Plan’s obligations to provide behavioral health services. Such statements are also inconsistent with the terms and conditions of coverage set forth in enrollee contracts. Having one’s provider state that needed mental health services are not available through the Plan discourages enrollees from accessing needed care.

The Department has determined that this deficiency remains uncorrected.

SECTION II: ADDITIONAL INFORMATION RECEIVED DURING THE FOLLOW-UP SURVEY

Throughout the Follow-Up Survey, the Department received numerous items of correspondence concerning possible timely access violations. The Department forwarded the correspondence to the Plan for review and response to the identified issues. The Plan responded beginning in November 2014 through February 5, 2015. As noted in the Survey Conclusion, the Department's investigation concerning issues of timely access to mental health services continues at this time. Accordingly, the information contained in these items of correspondence is not part of the information relied upon by the Department in reaching its conclusions set forth in this Follow-Up Survey Report.

SECTION III: SURVEY CONCLUSION

Based on all of the information provided and reviewed in connection with the Routine and Follow-Up Survey, the Department concludes that Deficiency #3 and Deficiency #4 remain uncorrected. The available information suggests that, although the Plan has taken steps in good faith to try to correct issues related to timely access to behavioral health services, significant and serious concerns remain.

The volatility in the Plan's monthly timely access reports reveal that the measures taken by the Plan to date are inadequate to provide consistent timely access to behavioral health care services for its enrollees. While the Department understands the unique hurdles the Plan continues to face in recruiting adequate staff and in using externally-contracted providers, these challenges do not relieve the Plan of its statutory obligation to take effective action to correct access and availability problems. The Plan's actions to date have not been adequate to ensure that its enrollees *consistently* have ready access to all mandated behavioral health services consistent with good professional standards of practice and established timely access standards.

Additionally, the Plan must take additional steps to ensure its providers immediately cease disseminating inaccurate information to enrollees concerning behavioral health benefits and coverage. That misleading health education information is disseminated verbally, and in writing, to patients by providers is of great concern to the Department.

The ongoing issues of Plan non-compliance have been referred to the Department's Office of Enforcement for further investigation and possible disciplinary action, based on the Plan's failure to correct Deficiencies #3 and #4.

In the event the Plan wishes 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, **2012 Routine Behavioral Health Survey - Document Request**.
- Submit the response to the Follow-Up Report via the "DMHC Communication" tab.

[Plan Response to the Follow-Up Report](#)