DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

NONROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

DBA: KAISER PERMANENTE

A FULL SERVICE HEALTH PLAN

FEBRUARY 25, 2025

Nonroutine Survey Final Report
Kaiser Foundation Health Plan, Inc.
DBA: Kaiser Permanente
A Full Service Health Plan

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EXECUTIVE SUMMARY

On May 16, 2022, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc. DBA Kaiser Permanente (Plan) of the Department's intent to conduct a nonroutine survey pursuant to Section 1382 and Rule 1300.82.1. The Department received complaints from enrollees, providers, and other stakeholders concerning the Plan's Mental Health and Substance Use Disorder (MH/SUD) operations. Issues included the Plan's internal and external provider networks (EPN), timely access to care, processes for intake and follow-up appointments, appointment scheduling processes, levels of care and associated decision-making processes, medical record documentation and retention practices, and monitoring of urgent appointments.

Based on these allegations, the Department had reason to believe the Plan was not meeting standards set forth in the Knox-Keene Health Care Service Plan Act of 1975, including, but not limited to, Sections 1367, 1367.03, 1370 and Rules 1300.67.2.2 and 1300.70. The Department initiated this nonroutine survey to ensure enrollees were receiving timely access to MH/SUD services.[1]

The onsite survey was conducted from November 7, 2022 through November 9, 2022 in the Northern California Region (NCAL) and from November 14, 2022 through November 15, 2022 in the Southern California Region (SCAL).

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Continuity of Care
Behavioral Health – SB 855

The Department identified **20** deficiencies during the Nonroutine Survey. The 2022 Survey Deficiencies Table below provides the status of each deficiency. The report describes each deficiency finding, Plan efforts to correct deficiencies and the Department's assessment of corrective action as well as the need for continued efforts and follow-up.

[1] As of March 31, 2022, the Plan reported 9,360,472 enrollees, including 6,975,642 commercial, 168,998 Medi-Cal, and 649,799 contracted from other health plans.

2022 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	NORTHERN CALIFORNIA	
1	**The Plan does not establish and maintain an adequate quality assurance monitoring system and process to ensure urgent appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.** Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1).	**Not Corrected**
2	**The Plan fails to ensure nonurgent appointments with nonphysician mental health care or substance use disorder providers are offered within 10 business days of the initial appointment request.** Section 1367.03(a)(5)(E), (H); Section 1367.03(e)(2); Rule 1300.67.2.2(c)(5)(E), (G).	**Not Corrected**
3	**The Plan does not promptly reschedule appointments in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.** Section 1367.03(a)(3); Rule 1300.67.2.2(c)(3).	**Not Corrected**
4	**The Plan's quality assurance program does not include the appropriate level of oversight to ensure clinicians are conducting suicide risk screenings, assessments, and treatment consistent with professionally recognized standards of practice.** Rule 1300.70(a)(1), (a)(4)(D), (b)(1)(A), (b)(2)(A)-(C).	**Not Corrected**
5	**The Plan does not ensure all processes necessary to obtain covered autism spectrum disorder services are completed in a timely manner consistent with good professional practice.** Section 1367.03(a)(2), (a)(5)(E), (e)(2); Rule 1300.67.2.2(c)(1)-(2), (c)(5)(E).	**Not Corrected**
6	**The Plan does not maintain an adequate system to document external provider referrals and monitor the follow-up of enrollees' health care documentation to ensure services are furnished in a timely and appropriate manner.** Section 1367(d); Rule 1300.67.1(d)-(e).	**Not Corrected**

7	**The Plan does not maintain medical records in a manner which provides continuity of care.** Rule 1300.67.1(c).	**Not Corrected**
8	**The Plan fails to monitor and take effective action to correct identified access issues.** Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1); Rule 1300.70(a)(1), (3), (b)(1)(B).	**Not Corrected**
9	**The Plan does not take effective action to improve care where grievance and appeal deficiencies are identified.** Rule 1300.70(a)(1).	**Not Corrected**
10	**The Plan's Quality Oversight Committee does not meet quarterly and is acting at variance with its committee charter.** Section 1351; Section 1386(b)(1); Rule 1300.51(d), Item J; Rule 1300.70(b)(2)(C).	**Corrected**
11	**The Plan's governing body and quality assurance committee do not adequately oversee their respective quality assurance program responsibilities.** Rule 1300.70(b)(2)(C).	**Not Corrected**
	SOUTHERN CALIFORNIA	
12	**The Plan fails to ensure nonurgent appointments with nonphysician mental health care or substance use disorder providers are offered within 10 business days of the initial appointment request.** Section 1367.03(a)(5)(E), (H); Section 1367.03(e)(2); Rule 1300.67.2.2(c)(5)(E), (G).	**Not Corrected**
13	**The Plan does not promptly reschedule appointments in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.** Section 1367.03(a)(3); Rule 1300.67.2.2(c)(3).	**Not Corrected**
14	**The Plan's quality assurance program does not include the appropriate level of oversight to ensure clinicians are conducting suicide risk screenings, assessments, and treatment consistent with professionally recognized standards of practice.** Rule 1300.70(a)(1), (a)(4)(D), (b)(1)(A), (b)(2)(A)-(C).	**Not Corrected**

15	**The Plan does not maintain an adequate system to document external provider referrals and monitor the follow-up of enrollees' health care documentation to ensure services are furnished in a timely and appropriate manner.** Section 1367(d); Rule 1300.67.1(d)-(e).	**Not Corrected**
16	**The Plan does not maintain medical records in a manner which provides continuity of care.** Rule 1300.67.1(c).	**Not Corrected**
17	**The Plan is unable to ensure enrollees are offered urgent care appointments within 48 hours of the request for the appointment.** Section 1367.03(a)(5)(A)-(B); Rule 1300.67.2.2(c)(5)(A)-(B).	**Not Corrected**
18	**The Plan fails to monitor and take effective action to correct identified access issues.** Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1); Rule 1300.70(a)(1), (3), (b)(1)(B).	**Not Corrected**
19	**The Plan's governing body and quality assurance committee do not adequately oversee their respective quality assurance program responsibilities.** Rule 1300.70(b)(2)(C).	**Not Corrected**
	STATEWIDE	
20	**The Plan does not ensure nonurgent follow-up appointments with a nonphysician MH/SUD provider are offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing MH/SUD condition.** Section 1367.03(a)(5)(F); Rule 1300.67.2.2(c)(5)(F).	**Not Corrected**

PLAN BACKGROUND

Northern California Region

In NCAL, the Plan contracts exclusively with The Permanente Medical Group (TPMG) for the provision of primary and specialty care services, including MH/SUD services.

The Plan and TPMG have a medical service agreement (MSA) in place which specifies the responsibilities of the two entities. The MSA requires TPMG to be solely responsible for the rendition of all medical services without intervention by the Plan. TPMG's service obligations include access to services, language assistance, quality review and improvement, economic profiling of providers, and payment of providers. In addition, the Plan and TPMG are required to cooperate and jointly administer quality assurance (QA), utilization management, and credentialing activities.

In NCAL, MH/SUD services are primarily furnished by TPMG providers. When additional resources are needed, TPMG contracts with external contracted providers.[2] In instances where TPMG and external contracted provider appointments are not available, TPMG directly contracts with individual out of network (OON) providers.[3]

As a licensed health care service plan, the Plan is ultimately responsible for ensuring TPMG providers, external contracted providers, and OON providers deliver quality MH/SUD care and timely services to enrollees.[4]

Southern California Region

In SCAL, the Plan contracts exclusively with the Southern California Permanente Medical Group (SCPMG) for the provision of primary and specialty care services, including MH/SUD services.

The Plan and SCPMG have an MSA in place which specifies the responsibilities of the two entities. The MSA requires SCPMG to be solely responsible for the rendition of all medical services without intervention by the Plan. SCPMG's service obligations include access to services, language assistance, quality review and improvement, economic profiling of providers, and payment of providers. In addition, the Plan and SCPMG are required to cooperate and jointly administer QA, utilization management, and credentialing activities.

[2] The Plan indicated TPMG's external contracted providers include Beacon Health, Magellan, AbleTo, Two Chairs, Pacific Coast Psychiatric Associates, Grow Healthcare Group, and Ginger. However, TPMG's appointment log was comprised of hundreds of external provider groups and individual external providers. Therefore, the complete list of external contracted providers is unknown.
[3] The number of OON providers is unknown, as the Plan and TPMG were unable to provide the Department with a list of enrollees referred to OON providers.
[4] Rule 1300.70(b)(2)(C) requires the Plan to establish a program to monitor and evaluate the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice. Rule 1300.70(b)(2)(G)(3) requires the Plan to have ongoing oversight procedures in place to ensure providers are fulfilling all delegated QA responsibilities. Section 1367.03(c) does not waive the Plan's obligation to comply with the timely access requirements if the Plan delegates to its provider groups or other contracting entities any services or activities the Plan is required to perform.

In SCAL, MH/SUD services are primarily furnished by SCPMG providers. When additional resources are needed, SCPMG contracts with external contracted providers.[5] In instances where SCPMG and external contracted provider appointments are not available, SCPMG directly contracts with individual OON providers.[6]

As a licensed health care service plan, the Plan is ultimately responsible for ensuring SCPMG providers, external contracted providers, and OON providers deliver quality MH/SUD care and timely services to enrollees.[7]

[5] The Plan indicated SCPMG's external contracted providers include Beacon Health, Center for New Directions, LifeStance Health, Soultenders, Cyti Psychology, Inc., and SUD Specialty Group. However, SCPMG's appointment log was comprised of hundreds of external provider groups and individual external providers. Therefore, the complete list of external contracted providers is unknown.
[6] The number of OON providers is unknown, as the Plan and SCPMG were unable to provide the Department with a list of enrollees referred to OON providers.
[7] Rule 1300.70(b)(2)(C) requires the Plan to establish a program to monitor and evaluate the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice. Rule 1300.70(b)(2)(G)(3) requires the Plan to have ongoing oversight procedures in place to ensure providers are fulfilling all delegated QA responsibilities. Section 1367.03(c) does not waive the Plan's obligation to comply with the timely access requirements if the Plan delegates to its provider groups or other contracting entities any services or activities the Plan is required to perform.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On September 4, 2024, the Department issued the Plan a preliminary report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to perform the following within 45 days of issuance of the preliminary report:

(a) Provide a written response to the Preliminary Report,
(b) Develop and implement a corrective action plan for each deficiency, and
(c) Provide the Department with evidence of the Plan's completion of, or progress toward, implementing those corrective actions.

This Final Report describes the deficiencies identified by the Department, the Plan's 45-day response and proposed corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts. The Department will reassess Plan compliance with all uncorrected deficiencies, including deficiencies that required more than 45 days to correct, during a follow-up survey within 18 months of issuance of this Final Report.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

NORTHERN CALIFORNIA

Deficiency #1: **The Plan does not establish and maintain an adequate quality assurance monitoring system and process to ensure urgent appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.**

Statutory and Regulatory References: Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1).

Assessment: Section 1367.03(a)(1) and Rule 1300.67.2.2(c)(1) require the Plan to 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. In addition, the Plan shall establish and maintain networks, policies, procedures, and QA monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

TPMG is required to offer urgent MH/SUD appointments that do not need prior authorization within 48 hours of request.[8] For urgent MH/SUD appointments requiring prior authorization, TPMG must offer an appointment within 96 hours of request.[9,10] Urgent appointments can be provided by TPMG providers, external contracted providers, and OON providers.

The Northern California Regional Access Committee (Access Committee) monitors behavioral health access and availability of services. Specifically:

> Each medical center's access performance is reported to the regional Access Committee monthly. Leadership at each local medical center reports to the regional Access Committee when access issues/trends are identified. The regional Access Committee serves as the Health Plan oversight body to ensure members are seen in a timely manner, in accordance with the DMHC's Timely Access Regulations. The committee proactively addresses areas at risk of not meeting those requirements. The Access Committee maintains ongoing reporting and communication with the medical center departments, committees, and/or leaders responsible for oversight of access to care.[11]

The Permanente Medical Group

In Northern California, the Plan operates 21 medical centers[12] in 11 service areas.[13,14] Each medical center submits access and availability and performance reports to the Access Committee. From May 1, 2019 through March 31, 2022, TPMG reported zero urgent appointments to the Access Committee for 10 service areas. Specifically:

1. Diablo: Zero urgent appointments reported for 28 months
2. Fresno: Zero urgent appointments reported for seven months
3. Napa-Solano: Zero urgent appointments reported for 23 months
4. North Valley: Zero urgent appointments reported for 26 months
5. Redwood City: Zero urgent appointments reported for 24 months
6. San Francisco: Zero urgent appointments reported for 26 months
7. San Rafael: Zero urgent appointments reported for eight months

[8] Section 1367.03(a)(5)(A), Rule 1300.67.2.2(c)(5)(A), and *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[9] Section 1367.03(a)(5)(B), Rule 1300.67.2.2(c)(5)(B), and *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[10] The *Oversight & Monitoring for Access and Availability* (Northern California Region) policy provides two timeframes for urgent MH/SUD appointment requests depending on whether prior authorization is necessary. This policy is inconsistent with the 2022 *Kaiser Permanente Member Resource Guide* (page 7), which requires TPMG to offer urgent MH/SUD appointments to enrollees within 48 hours regardless of whether prior authorization is necessary.
[11] *Summary of Quality Assurance Oversight of Behavioral Health Care Access*, page 3.
[12] The 21 medical centers are located in Antioch, Fremont, Fresno, Hayward, Manteca, Modesto, Oakland, Redwood City, Richmond, Roseville, Sacramento, South Sacramento, San Francisco, San Jose, San Rafael, Santa Clara, Santa Rosa, South San Francisco, Vacaville, Vallejo, and Walnut Creek.
[13] The 11 service areas are Central Valley, Diablo, East Bay, Fresno, Golden Gate, Greater Sacramento, Greater Southern Alameda, Napa-Solano, San Mateo, Santa Rosa, and South Bay.
[14] Link to Plan's list of service areas.

8. Santa Clara: Zero urgent appointments reported for 20 months
9. Santa Rosa: Zero urgent appointments reported for three months
10. South San Francisco: Zero urgent appointments reported for 26 months

Despite prolonged periods of time where zero urgent MH/SUD services were reported in major Northern California cities, there was no documented discussion of this issue in the Access Committee meeting minutes. Also, it is unknown why data reported is from service areas instead of medical centers. Although potentially problematic urgent appointment data was reported, the Access Committee failed to identify and investigate this issue to ensure urgent MH/SUD appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

In addition, the Plan submitted an appointment log containing data from 15 service areas.[15] The log contained no urgent appointment data for 10 service areas from May 1, 2019 through March 31, 2022. Specifically:

1. Diablo: No urgent appointments reported for five months
2. Fresno: No urgent appointments reported for five months
3. Napa-Solano: No urgent appointments reported for 23 months
4. North Valley: No urgent appointments reported for 20 months
5. Redwood City: No urgent appointments reported for nine months
6. San Francisco: No urgent appointments reported for 24 months
7. San Jose: No urgent appointments reported for two months
8. San Rafael: No urgent appointments reported for five months
9. Santa Clara: No urgent appointments reported for 18 months
10. South San Francisco: No urgent appointments reported for 27 months

It is unknown why the data in the Access Committee reports and appointment log is inconsistent. This inconsistent reporting of urgent appointment data to the Access Committee and Department demonstrates the Plan does not have adequate QA monitoring systems and processes to ensure urgent MH/SUD appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

During interviews on November 7, 2022, the Department informed the Plan and TPMG of the lack of urgent appointment data in the log. The Plan and TPMG indicated clinicians manually document urgent appointments in a textbox and stated this issue needed to be explored. On January 10, 2023, over two months after this issue was initially discussed, the Plan submitted a narrative response:

> The Plan's Log 5 appointment data appeared to be missing some urgent appointments booked and completed in certain service areas during the requested time period. This was due to the fact that, in certain cases, local clinicians at the medical center levels did not consistently label urgent appointments as "urgent" in the [Patient Appointment Registration &

[15] Log #5 Appointments for TPMG providers.

> Reporting System (PARRS)] appointment scheduling system when booking appointments that were being treated as urgent. When the Log 5 appointment data was pulled from PARRS, the data set included these "urgent" appointments, but some were not labeled as "urgent" in the data set because they were not labeled as "urgent" by clinical staff at the time of booking in PARRS. This issue was not known at the time the Log 5 data was produced. To be clear, this was a data/labeling issue, not a clinical issue. Urgent appointments were handled appropriately from a clinical perspective.[16]

The Plan submitted no evidence to support its contention "this was a data/labeling issue, not a clinical issue." In addition, it is unknown how TPMG and the Plan were able to determine "urgent appointments were handled appropriately from a clinical perspective" when they were unable to identify where and when these appointments occurred.

Based on the Access Committee's failure to identify and investigate the prolonged underreporting of urgent MH/SUD appointments, the inconsistent reporting of urgent appointment data to the Access Committee and Department, and the TPMG clinicians' failure to consistently document urgent appointments in the system, the Plan is unable to ensure urgent MH/SUD appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

External Contracted Providers

TPMG contracts with external provider groups and individual providers when additional resources are needed. During interviews, TPMG identified Beacon Health, AbleTo, Pacific Coast Psychiatric Associates, Grow Healthcare Group, and Two Chairs as its external contracted provider groups, but was unable to provide the exact number of groups. TPMG additionally stated the number of individual contracted providers is "a hard number to pinpoint as providers are constantly shifting." TPMG estimated at a minimum, hundreds of external contracted providers, but was also unable to provide the exact number of providers.

TPMG reports urgent appointment timely access data to the Access Committee. The only external contracted provider group data reported to the Access Committee was from Beacon Health and Magellan. Zero urgent appointments were reported for both provider groups.[17] No data was reported for external individual contracted providers.

Additionally, the Plan submitted an external contracted provider appointment log containing 1,014 unique external contracted provider groups and individuals.[18] Although Access Committee data indicated zero urgent Beacon Health and Magellan appointments, the log contained 121 urgent Beacon Health appointments, 72 urgent

[16] N106_Plan Response.
[17] For Beacon Health, zero urgent appointments were reported from April 2019 through December 2020. For Magellan, zero urgent appointments were reported from April 2019 through March 2022.
[18] Log #5 Appointments for contracted providers.

Magellan appointments, and 79 urgent appointments completed by other external contracted providers for the period of January 1, 2020 through March 31, 2022.[19] During interviews, the Plan stated log data was pulled from claims, as claims are the only way TPMG is aware of completed external contracted provider appointments. This method of tracking appointments through claims data is problematic because the log does not contain offered urgent appointments that were not completed.

Although TPMG contracts with hundreds of external provider groups and individual providers, the Access Committee only reviewed urgent appointment data from Beacon Health and Magellan and failed to monitor the timeliness of urgent appointments provided by other external contracted providers. In addition, TPMG is unable to track and monitor the timeliness of urgent appointments as the appointment log is solely comprised of claims data from completed appointments and does not include all offered urgent appointments. TPMG and the Plan did not provide evidence to demonstrate an adequate QA monitoring system and process was established and maintained to ensure urgent MH/SUD appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

Out of Network Providers

TPMG contracts with OON providers when TPMG and external contracted providers are unavailable. The Access Committee reports do not include OON urgent appointment data. In addition, the OON provider appointment log did not contain urgent appointments.[20] TPMG and the Plan did not provide evidence to demonstrate an adequate QA monitoring system and process was established and maintained to ensure urgent MH/SUD appointments are provided or arranged in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> While the Plan does not fully agree with the Department's findings regarding TPMG, it has already taken action to improve its processes for monitoring urgent appointments with TPMG providers. The Plan is also exploring ways to improve its system and process for monitoring urgent appointments with external providers…
>
> TPMG's Regional Mental Health team prioritized Urgent Access in 2023 and 2024, focusing on root cause analysis, training, workflow design, and volume threshold setting to improve care delivery. The root cause investigation revealed that the shift from PARRS to Cadence (appointment scheduling systems) did not fully transfer the codes used for urgent care to the new system. In addition, based on consultation with child psychiatrists, the team concluded that the low volumes reported for "MD Child" urgent access was the result of best clinical practices. In particular,

[19] The log consists of four types of appointments – "NEW," "RET," "URG," and "OTHER." The true number of completed urgent appointments is unknown because new, returning, and other appointments could also be urgent.
[20] N89_DMHC LFP Referral Report.

for the pediatric population, patients in crisis should be assessed by a therapist before medication intervention is considered.

Based on its root cause investigation, the Regional Mental Health Team implemented several interventions, including the following:

- Training: From February to April 2023, the team shared updates, gathered feedback, and defined best practices to improve urgent appointment management;
- Daily Oversight on Timeliness: Beginning May 2023, we assigned a consultant to monitor Urgent Appointment Access daily;
- Clinical Definition of Urgent: The Management-Labor Coalition developed recommendations for new crisis workflows to clinically define urgent indications that were previously subject to individual clinical assessments;
- Monitoring and Adjustments: By July 2023, a new dashboard was developed to track Urgent Access statistics. This dashboard was distributed to all service areas for instantaneous and convenient transparency into urgent care; and
- Targets: In August 2023, volume targets were set and monitored to address regional disparities, including with the use of Access Managers to oversee Urgent Access in each service area.

In addition, the Regional Mental Health Team has updated the reporting tool to include all urgent care delivered in the system, including at 15-minute and 30-minute visits, and has also set minimum threshold standards for clinics to meet.

The Plan is currently evaluating ways to remediate the deficiency with respect to monitoring external providers, including both contracted and [OON] providers. In particular, the Access Committee has discussed ways to expand its reporting system to include additional external contracted providers. Possible solutions include efforts to expand external Tridiuum and/or [Kaiser Permanente (KP)] Direct systems to such providers.

In addition, the Plan asserted:

This deficiency and any corrective actions associated with it are incorporated into the Settlement Agreement. In particular, the finding is within the scope of Corrective Action Area [Number (No.)] 1: Oversight. With respect to that Corrective Action Area, the [Corrective Action Work Plan (CAWP)] currently includes plans to:

- improve general governance (e.g., hiring regional and statewide VPs for Behavioral Health & Wellness, Associate CMO of Mental

Health & Wellness);

- strengthen committees (e.g., expanding the scope and functions of regional [Behavioral Health Quality Oversight Committee (BHQOCs)], [Quality and Health Improvement Committee (QHIC)] to review and approve regional committees' analyses and recommendations);

- increase staff for regional behavioral health and wellness teams; and

- improve data analytics capabilities.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 3: MH Urgent Care Access Interventions 2023-2024 (October 18, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed and undertaken, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of appointment data, reports and reporting tools, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #2: The Plan fails to ensure nonurgent appointments with nonphysician mental health care or substance use disorder providers are offered within 10 business days of the initial appointment request.

Statutory and Regulatory References: Section 1367.03(a)(5)(E), (H); Section 1367.03(e)(2); Rule 1300.67.2.2(c)(5)(E), (G).

Assessment: Section 1367.03(a)(5)(E), Rule 1300.67.2.2(c)(5)(E), and the Plan's *Oversight & Monitoring for Access and Availability* policy require the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees nonurgent appointments with a nonphysician mental health care or substance

use disorder provider within 10 business days of the request for the appointment.[21] Section 1367.03(a)(5)(H) and Rule 1300.67.2.2(c)(5)(G) allow this 10 business day requirement to be extended if the provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Section 1367.03(e)(2) defines "appointment waiting time" as:

> ...the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the Plan or completing any other condition or requirement of the Plan or its contracting providers.

During interviews, TPMG stated enrollees can self-refer or request a referral through their primary care provider to receive a MH/SUD appointment. Enrollees are then triaged to determine disposition. If urgent or emergent care is not needed, then enrollees are scheduled an intake appointment. TPMG further stated the 10-business day requirement applies to intake, not triage, as the intake appointment marks the beginning of treatment.

The Department reviewed 71 TPMG Appointment Request (AR) 1 files, 70 TPMG AR 2 files, and 71 TPMG AR 3 files.[22] Of these files, 54 TPMG AR 1 files (76%),[23] 60 TPMG AR 2 files (86%),[24] and 45 TPMG AR 3 files (63%)[25] failed to demonstrate intake appointments were offered within 10 business days of the initial request for health care services by an enrollee or the enrollee's treating provider.

Case Examples

- **DMHC TPMG AR 1 File 10:** The nine-year-old enrollee's mother called to request treatment for Attention Deficient Hyperactivity Disorder (ADHD) on October 4, 2021. Triage occurred on the same date and the enrollee was "Referred to Provider, referred to ADHD team for follow-up." The enrollee's mother followed up on October 13, 2021 and October 25, 2021 and expressed her frustration as no one has contacted her. The enrollee was finally scheduled for a virtual "ADHD observation group" on November 8, 2021, 25 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10 business

[21] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[22] TPMG AR 1 Files include appointments documented as canceled by the enrollee. TPMG AR 2 Files include appointments documented as canceled by the provider. TPMG AR 3 Files include appointments documented as "no show."
[23] DMHC TPMG AR 1 Files 1-5, 7-12, 14, 16-20, 22, 23, 25, 27, 29, 31-33, 35, 37, 38, 40, 42-46, 48-52, 55, 57-67, 69-71.
[24] DMHC TPMG AR 2 Files 1-8, 10-17, 19-32, 34, 38, 39, 41-44, 48-68, 70, 71.
[25] DMHC TPMG AR 3 Files 2, 3, 8-13, 15, 19, 21, 22, 25-31, 34, 35, 37-44, 48-60, 63, 66, 70, 71.

days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

- **DMHC TPMG AR 2 File 63:** The enrollee initially sought treatment for ADHD and Attention Deficit Disorder on April 15, 2020. There was no documentation of the details of the referral. Triage occurred on April 16, 2020. The enrollee was scheduled for an intake appointment with a TPMG psychologist on May 4, 2020, 14 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10 business days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

- **DMHC TPMG AR 3 File 27:** On March 2, 2020, the enrollee's mother messaged the physician requesting a therapy referral for the enrollee and was instructed to "call front desk and ask them to transfer to nurse." The nine-year-old enrollee was already receiving medication management services for ADHD from a TPMG physician. On March 6, 2020, it was documented the enrollee's mother again called to schedule a therapy appointment for the enrollee. The screening appointment was scheduled for March 24, 2020, 17 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10 business days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

TABLE 1
Nonurgent Appointments with Nonphysician MH/SUD Providers

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
TPMG AR 1	71	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	17 (24%)	54 (76%)
TPMG AR 2	70	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	10 (14%)	60 (86%)

TPMG AR 3	71	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	26 (37%)	45 (63%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated the "finding was included in and addressed in connection with the CAWP as part of Corrective Action Area Number 2: Access, and Corrective Action Area Number 3: Network & Referrals." In addition:

> …These issues were also identified in the Settlement Agreement, and the Plan has been engaged in ongoing efforts to correct the deficiency as described below and in the CAWP…
>
> As described in the Settlement Agreement, the Plan made commitments to "improve its procedures to ensure that its enrollees can access behavioral health appointments consistent with timely access standards." The Plan has made good on that commitment by significantly expanding its provider network and by developing the CAWP…
>
> This deficiency and any corrective actions associated with it are incorporated into the Settlement Agreement. In particular, the finding is within the scope of Corrective Action Area No. 2: Access. With respect to that Corrective Action Area, the CAWP currently includes (but is not limited to) the following relevant actions:
>
> - Expand the external contracted network by more than 7,500 clinicians;
> - Increase internal medical group staffing;
> - Refine the supply and demand dashboard as needed based on the Behavioral Health team's analysis;
> - Ensure monthly monitoring of each medical center's compliance with timely access requirements;
> - Ensure monthly monitoring of documentation of non-detriment statements for initial access and SB 221 standards;
> - Ensure comparable analysis is performed across external contracted providers; and
> - Provide virtual treatment for mild to moderate depression or anxiety through the [Achieving Depression and Anxiety Patient-Centered

Treatment (ADAPT)] program.

This deficiency may also be deemed to be within the scope of Corrective Action Area No. 3: Network & Referrals. With respect to that Corrective Action Area, the CAWP currently includes actions aimed at expanding the provider network, as well as improving the process for making and monitoring referrals to external providers.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 3: MH Urgent Care Access Interventions 2023-2024 (October 18, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of appointment data, reports and reporting tools, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #3: The Plan does not promptly reschedule appointments in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.

Statutory and Regulatory References: Section 1367.03(a)(3); Rule 1300.67.2.2(c)(3).

Assessment: If it is necessary for a provider or an enrollee to reschedule an appointment, Section 1367.03(a)(3), Rule 1300.67.2.2(c)(3), and the Plan's *Oversight & Monitoring for Access and Availability* policy require the Plan to promptly reschedule the appointment in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.[26]

During interviews, TPMG stated it is the provider's responsibility to follow-up with the enrollee after a missed or canceled appointment. TPMG indicated it does not have a consistent process to reschedule appointments, as each medical center has its own process. TPMG further stated it reviews every canceled and missed appointment to

[26] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.

ensure providers follow-up with enrollees but admitted it does not conduct any oversight to ensure follow-up occurs.

The Department reviewed 71 TPMG AR 1 files, 70 TPMG AR 2 files, and 71 TPMG AR 3 files. Of these files:

- TPMG AR 1: 32 out of 71 files (45%)[27] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 32 files, 11 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[28]

- TPMG AR 2: 41 out of 70 files (59%)[29] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 41 files, 12 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[30]

- TPMG AR 3: 42 out of 71 files (59%)[31] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 42 files,19 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[32]

Case Examples

- **DMHC TPMG AR 1 File 17:** The teenage enrollee, diagnosed with ADHD, was prescribed Adderall, and was receiving medication management services.

  Medical records showed a February 3, 2020 medication appointment was canceled. However, there was no documentation of who canceled the appointment, why the appointment was canceled, or any attempts by the provider to reschedule the appointment. While the medical records documented a completed telephone visit with the enrollee's mother on August 12, 2020 (six months after the missed appointment), there were no records associated with this visit. Notably, although the enrollee was taking Adderall,[33] there was only one completed telephone appointment over a two-year period.

[27] DMHC TPMG AR 1 Files 1, 2, 4, 5, 7-9, 11, 17, 18, 23-26, 28, 31, 32, 35, 38, 40, 41, 49, 50, 54, 55, 59, 62, 63, 67-69, 71.
[28] DMHC TPMG AR 1 Files 4, 5, 18, 23, 25, 26, 32, 50, 62, 67, 68.
[29] DMHC TPMG AR 2 Files 2-7, 9-13, 15-17, 19, 23-25, 27-29, 31, 36, 38, 40-43, 46, 51, 54, 56, 58-60, 62, 63, 65, 67, 70, 71.
[30] DMHC TPMG AR 2 Files 2, 15, 23, 29, 42, 43, 46, 54, 60, 62, 70, 71.
[31] DMHC TPMG AR 3 Files 1-3, 5, 7-9, 16, 18-30, 33, 35, 38, 42-44, 49-51, 53-56, 59, 61-63, 65, 66, 69, 70.
[32] DMHC TPMG AR 3 Files 2, 7, 9, 16, 18, 22, 24, 26, 28, 30, 38, 43, 44, 55, 61, 63, 65, 69, 70.
[33] Adderall is a Schedule II controlled substance with a high potential for physical and psychological dependence, as well as abuse and diversion. Link to FDA Medication Guide for Adderall.

This file is deficient because the canceled appointment was not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

- **DMHC TPMG AR 2 File 46:** The enrollee was consistently seeing a provider in July and August 2021 for depression, relationship problems, and trauma. The provider left the practice at the end of August and informed the enrollee care would be transferred. After the last appointment with the provider on August 13, 2021, the next documented appointment with a new provider was scheduled for November 15, 2021. This appointment was canceled. There was no documentation of who canceled the appointment, why the appointment was canceled, or any attempts by TPMG to reschedule the appointment.

  The next appointment was scheduled for December 8, 2021, almost four months after the enrollee's last encounter in August. This appointment was also canceled. The enrollee was sent a secure message which stated, "Due to provider illness, we will need to cancel out your appointment today at 1:00." The message instructed the enrollee to call the clinic to reschedule the appointment.

  There were no further appointments documented in the file. There was no documented outreach to the enrollee to reschedule the appointment or evidence of further engagement with the enrollee. For both canceled appointments, there was no documentation whether, in the opinion of the provider, the interval between appointments was appropriate for the enrollee's health care needs. Rather, TPMG placed the responsibility on the enrollee to reschedule the December appointment canceled by the provider.

  This file is deficient because the canceled appointments were not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

- **DMHC TPMG AR 3 File 3:** The enrollee was receiving medication management services for major depressive disorder and ADHD. An appointment with a physician scheduled for September 13, 2019 was canceled. There was no documentation of who canceled the appointment, why the appointment was canceled, or any attempts by the provider to reschedule the appointment.

  On September 25, 2019, the enrollee contacted the physician to request a follow-up appointment. An appointment was scheduled for October 4, 2019. At that appointment, the physician recommended six-to-12-month follow-up appointments. However, the enrollee's next follow-up appointment was scheduled for July 20, 2021, almost two years later. Records showed the enrollee failed to attend the appointment. There was no documented outreach to the enrollee to reschedule the appointment or to assess whether the interval between appointments was appropriate for the enrollee's health care needs.

This file is deficient because the appointment was not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

TABLE 2
Rescheduled Appointments

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
TPMG AR 1	71	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	39 (55%)	32 (45%)
TPMG AR 2	70	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	29 (41%)	41 (59%)
TPMG AR 3	71	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	29 (41%)	42 (59%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan acknowledged the Department's findings "were also identified in the Settlement Agreement, and the Plan has been engaged in ongoing efforts to correct the deficiency."

The Plan indicated "TPMG has adopted a consistent process to reschedule appointments" in 2023 and provided the Department with slides on its procedures for rescheduling appointments. Additionally, the Plan asserted all corrective actions required to remediate this deficiency "are incorporated into the Settlement

Agreement…within the scope of Corrective Action Area No. 2: Access." The Plan specifically noted the CAWP currently includes plans to:

- Strengthen and standardize policies and processes relating to initial follow-up and rescheduled behavioral health appointment access; and

- Expand monitoring of Medical Groups' return access availability.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 1: Settlement Agreement (October 11, 2023)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 4: Booking, eConsult and Documentation Procedures for Psychiatry/AMRS: Compliance Training, 2023 Version (2022)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of appointment data, reports and reporting tools, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #4: The Plan's quality assurance program does not include the appropriate level of oversight to ensure clinicians are conducting suicide risk screenings, assessments, and treatment consistent with professionally recognized standards of practice.

Regulatory References: Rule 1300.70(a)(1), (a)(4)(D), (b)(1)(A), (b)(2)(A)-(C).

Assessment: Rule 1300.70(b)(1)(A) requires the Plan to ensure a level of care which meets professionally recognized standards of practice is being delivered to all enrollees.

Rule 1300.70(b)(2)(A) mandates the Plan to maintain a written QA plan describing its methodology for on-going monitoring and evaluation of health services. To the extent the Plan's QA responsibilities are delegated within the Plan or to a contracting provider, Rule 1300.70(b)(2)(B) requires the Plan's documents to provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Rule 1300.70(b)(2)(C) mandates delegated entities to maintain records of its QA activities and actions. Further, the Plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice.

Rule 1300.70(a)(1) requires the Plan's QA program to document the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Finally, Rule 1300.70(a)(4)(D) authorizes the Department to evaluate "the level of activity of the [Plan's QA] program and its effectiveness in identifying and correcting deficiencies in care."

Professionally recognized standards of practice require clinicians to conduct a suicide risk screening and/or assessment for all enrollees receiving MH/SUD services during triage, intake, and as indicated thereafter.[34,35] Furthermore, for enrollees who have a documented risk of suicide, a level of care that is appropriate to the enrollees' assessed risk must be delivered in a timely manner.

The Plan delegates the responsibility to "oversee and monitor the performance of Behavioral Health (BH) care inpatient and outpatient initiatives" to the BHQOC.[36] The BHQOC reports to the Quality Oversight Committee (QOC),[37] which in turn reports to the QHIC, a subcommittee of the Plan's governing body.[38]

The BHQOC is responsible for monitoring "trends and system barriers related to suicide throughout the organization and make recommendations to address relevant system problems and promote improvements in care."[39] In addition, the Regional Psychiatry and Addiction Medicine Quality Committee (PAMQC) reports to the BHQOC and provides coordination and oversight for suicide prevention.[40]

The Department determined the Plan failed to demonstrate its QA program includes sufficient level of oversight to ensure enrollees receive suicide risk screening,

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[34] Simon, Robert I. "Suicide Risk Assessment: What is the Standard of Care?" Journal American Academy Psychiatry Law, Volume 30, pages 340-344, 2002.
[35] The Joint Commission, "the nation's oldest and largest standards-setting and accrediting body in health care," introduced a national patient safety goal for suicide prevention. Link to Joint Commission FAQs. Behavioral health care organizations are required to screen all patients using a validated screening tool. The PHQ-9 is one of several specifically mentioned examples. Further, an evidence-based risk assessment is required following a positive screen for thoughts of suicide. The Columbia Suicide Severity Rating Scale is one of the examples listed as an evidence-based risk assessment tool. Link to The Joint Commission. National Patient Safety Goal for suicide prevention: NPSG 15.01.01, EP 2. R3 Report: Issue 18, May 2019, pages 2-3.
[36] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 77.
[37] *Id*.
[38] *Id*., pages 7, 43.
[39] *Id*., page 14.
[40] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 109.

assessment, and treatment consistent with professionally recognized standards of practice. The Department reviewed the BHQOC meeting minutes and found the committee only reviewed two reports regarding suicide trends during the survey review period.[41] Both reports were limited to analysis of suicide screening as related to attempted and completed suicides in the Plan's emergency departments (ED) and the inpatient population. The Department found no evidence the BHQOC monitored trends and system barriers related to suicide in the Plan's outpatient behavioral health care system.

In addition, the BHQOC meeting minutes reflect the committee received periodic medical record audit reports. These reports indicate the Plan reviews triage records to evaluate whether it includes documentation the clinician completed a suicide risk screening.[42,43] However, the Department found no evidence the Plan also assessed whether the triage clinician responded appropriately to any risk factors identified as a result of the suicide screening. Similarly, the Plan's audit reports indicate it reviews behavioral health treatment plans to evaluate whether the provider documented the enrollee's treatment plan and goals.[44] Again, the Department found no evidence the Plan assessed whether treatment plans reflected a level of care appropriate for any documented risk of suicide. Taken together, the Department found the Plan did not submit evidence it performs sufficient monitoring activities to identify quality of care issues related to suicide risk assessment and treatment.

The Department also determined the Plan failed to demonstrate it takes effective action to improve care where deficiencies are identified and performs follow-up where indicated. The Department found evidence the BHQOC identified quality of care issues related to suicide prevention. In its May 20, 2020 meeting minutes, the BHQOC states its "Major concerns, challenges and primary areas of focus" include:

1. Suicide Screening
    a. A common causal factor seems to be the "lack of suicide assessment"…
    b. The proper screening and assessment seem to be a major key and that should be one of the key messages.
    c. ED Directors and ED Chiefs to review suicide assessment processes related to…completing the suicide screening.
2. Suicide Assessment
    a. PCS Directors and Security need to review suicide precaution monitoring and communication processes.[45]

[41] *Behavioral Health Quality Oversight Committee* Meeting Minutes, May 20, 2020 and May 19, 2021.
[42] The Plan limits its Triage Audits to records of enrollees for whom the Plan was unable to offer an intake appointment within applicable timely access standards. The Plan provided no evidence it audits any other behavioral health triage records for suicide risk screening.
[43] Q2 2019 Northern California Treatment Plan and Triage Audit Summary, page 7.
[44] *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019, pages 4-6.
[45] *Behavioral Health Quality Oversight Committee* Meeting Minutes, May 20, 2020, page 11. KP NCAL Suicide Analysis 2018-April 2020 (May 1, 2020), page 11.

To address these concerns, BHQOC meeting minutes indicated the Plan's "ED implemented the Columbia Suicide Severity Rating Scale (C-SSRS) on Health Connect, an evidence-based tool to identify and assess individuals at risk for suicide" and "released updated policy: Management of Behavioral Health Patients in the Emergency Department." In addition, the following steps were proposed for 2020:

- Inpatient Suicide workgroup to implement NCAL Compliance with [National Patient Safety Goal (NPSG)] 15.01.01: Reduce the Risk for Suicide
- KP NCAL inpatient departments will implement the [C-SSRS] in KP Health Connect in 2020
- KP NCAL inpatient workgroup will develop an inpatient suicide prevention workflow and create an NCAL Regional Suicide Precautions, Inpatient Services policy[46]

However, the Plan provided no documentation demonstrating the BHQOC followed up on these actions to evaluate their effectiveness in resolving the identified quality of care issues. The May 19, 2021 BHQOC meeting minutes only include a brief summary of the Annual KP NCAL Regional Risk Management Presentation – Suicide Report Out, stating:

> The Inpatient C-SSRS project workgroup created workflows for the ED, Adult, OB, and pediatric departments; revised the inpatient suicide prevention policy, standardized the environmental safety room readiness checklist; implemented the C-SSRS in the inpatient departments on 7/29/20; formed a Physician Best Practice Alert (BPA); created a Patient Discharge Education document; provided education and training to nurses and physicians; created KPHC dashboards and Tableau reports; and developed a comprehensive regional suicide prevention playbook.[47]

During this same meeting, the BHQOC received a report regarding attempted and completed suicides in 2020.[48] The meeting minutes include no evidence the BHQOC discussed the 2020 suicide data trends or made recommendations to promote improvements in care.

Finally, the Department determined the Plan failed to provide evidence it maintains an oversight mechanism to ensure delegated QA functions are adequately performed. The Plan submitted no documentation describing how it ensures the BHQOC performs its QA responsibilities as described in the Plan's Quality Program Description. Further, the Department reviewed QOC meeting minutes for the survey review period and found no evidence the committee identified the BHQOC's failure to monitor trends and system barriers related to suicide throughout the organization and make recommendations to address relevant system problems. In addition, the February 17, 2021 PAMQC Report

[46] *Behavioral Health Quality Oversight Committee* Meeting Minutes, May 20, 2020, page 12. KP NCAL Suicide Analysis 2018-April 2020 (May 1, 2020), page 12.
[47] *Behavioral Health Quality Oversight Committee* Meeting Minutes, May 19, 2021, pages 2-3.
[48] 2020 KP NCAL Suicide Analysis and Inpatient C-SSRS Project (May 20, 2020).

included the activities of the committee from January 2020 through January 2021. The report contained no mention of suicide risk assessment oversight and monitoring.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> The Plan further notes that the Department's findings are inconsistent with available minutes and reports, including BHQOC minutes.
>
> The Plan notes that the Department's purported findings relate to documents and information from nearly five years ago and precede the Plan's 2023 Behavioral Health Settlement Agreement. The [CAWP] the Plan has implemented pursuant to that Settlement Agreement will encompass suicide risk assessments. The changes covered by the Work Plan includes, among other things, expansion of the scope and functions of the BHQOCs including increasing the depth and frequency of their monitoring of performance on quality metrics and compliance with regulatory requirements and clinical quality treatment plan audits. Specific changes and oversight enhancements include, but are not limited to, the following:
>
> - Chart notes are audited daily by a team of licensed clinicians, checking for documentation of clinically appropriate [Suicidal Ideation (SI)] risk screenings in triage encounters;
> - Audit results are compiled monthly to identify service areas that are deficient in documenting SI risk screenings;
> - Corrective Action Plans are issued by the Plan monthly to service areas where SI risk screening documentation is below the Plan's performance threshold and a list of affected service areas is sent to regional leaders for review;
> - Regional leaders have access to real time dash boards containing data on SI risk screening documentation;
> - Service areas that are issued Corrective Action Plans for SI risk screening documentation deficiencies are required to have an administrator attend a monthly BHQOC subcommittee meeting to review corrective action interventions developed by service area administrators to address identified shortcomings in SI risk screening documentation;
> - Quarterly reports are submitted to BHQOC on trends in SI risk screening documentation in triage encounters;
> - Ongoing tracking and monitoring of depression levels and PHQ9 scores via BHQOC;
> - Weekly reviews are conducted by the Plan on cases identified to have quality, safety or regulatory deficiencies and cases identified as needing medical group follow up are sent to medical group regional leaders for review and action;

- During the Plan's chart audits, cases identified as containing a safety concern are directly escalated to medical group regional leaders for review, action and reporting of resolution; and
- Plan chart audits are expanding to include a review of SI risk screening documentation, use of PHQ9 and Columbia Scale in completed initial intake appointments, triage encounters with appointments booked within regulatory standards, and external provider initial intake appointments.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (February 21, 2025)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan submitted no evidence to demonstrate the "changes and oversight enhancements" were implemented. In addition, the Plan did not provide any committee meeting minutes and reports or explanation to demonstrate how "the Department's findings are inconsistent with available meetings and reports."

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of chart audits, corrective action plans, reports, policies and procedures, meeting minutes, files, interviews, and any other review deemed necessary by the Department.

Deficiency #5: The Plan does not ensure all processes necessary to obtain covered autism spectrum disorder services are completed in a timely manner consistent with good professional practice.

Statutory and Regulatory References: Section 1367.03(a)(2), (a)(5)(E), (e)(2); Rule 1300.67.2.2(c)(1)-(2), (c)(5)(E).

Assessment: Section 1367.03(a)(2) and Rule 1300.67.2.2(c)(2) require the Plan to ensure all plan and provider processes necessary to obtain covered health care services are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with statutory and regulatory access standards.

Section 1367.03(a)(5)(E), Rule 1300.67.2.2(c)(5)(E), and the Plan's *Oversight & Monitoring for Access and Availability* policy mandate the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees

nonurgent appointments with a nonphysician MH/SUD provider within 10 business days of the request for appointment.[49]

Section 1367.03(e)(2) defines "appointment waiting time" as:

> ...the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers.

Rule 1300.67.2.2(c)(1) requires the Plan to provide covered services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

TPMG requires enrollees seeking autism spectrum disorder (ASD) services to participate in a multi-step intake and assessment process.[50] Requested ASD services are arranged only after the following three steps are completed:

- First, the enrollee's parents must participate in a telephone appointment visit (TAV).[51] TPMG requires staff to either complete a TAV or make a best effort to contact the enrollee's parents within five business days[52] following receipt of the request for ASD services.[53]

- Second, the enrollee's parents must complete and return a questionnaire packet within six weeks after receiving the packet.[54,55]

- Third, the enrollee must attend an in-person evaluation to determine if they meet criteria for an ASD diagnosis. In-person evaluations are offered at three ASD

[49] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[50] *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019 ASD Program report, page 3.
[51] *Id*.
[52] TPMG originally required staff to complete a TAV within three business days of receipt of the request. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019. TPMG changed this timeframe to five business days in 2020. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 19, 2020, page 6.
[53] During the TAV, TPMG staff provide information about the ASD program to the enrollee's parents. The Department found no evidence to demonstrate TPMG provides any diagnostic or therapeutic services to the enrollee during the TAV, so this is not considered to be the initial appointment that is required to be offered within 10 business days of the appointment request.
[54] The Department found evidence suggesting TPMG permitted a limited exception to the packet requirement for enrollees ages 0-3. For these enrollees, TPMG allowed staff to proceed with booking an in-person evaluation prior to their parents returning the packet. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019 ASD Program report, page 1.
[55] The Plan submitted documentation indicating TPMG suspended its packet requirement as a pre-requisite for Medi-Cal enrollees to schedule an in-person ASD evaluation in 2020. However, the Department found no evidence to demonstrate TPMG discontinued this practice for commercial enrollees. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 19, 2020 ASD Program report, page 1.

evaluation centers located in San Jose, San Francisco, and Rancho Cordova.[56] TMPG requires staff to offer in-person evaluation appointments within 60 calendar days of receipt of the request for ASD services.[57]

Taken together, this process could result in enrollees waiting up to eight weeks before receiving an ASD evaluation and diagnosis, far exceeding the requirement to offer an appointment within 10 business days of request for services set forth in Section 1367.03(a)(5)(E) and Rule 1300.67.2.2(c)(5)(E).

In addition, once an enrollee is diagnosed with ASD, TPMG's process requires an appointment for treatment services to be offered within six weeks after completion of the in-person ASD evaluation.[58] This process again exceeds the 10-business day requirement set forth in Section 1367.03(a)(5)(E) and Rule 1300.67.2.2(c)(5)(E).

Factoring in TPMG's diagnostic processes, enrollees could wait upwards of four months before receiving ASD treatment services. Thus, the Department found TPMG's system of delivering ASD services creates significant barriers and prohibits enrollees from obtaining timely access to medically necessary treatment consistent with professionally recognized standards of practice.[59] Furthermore, the Plan failed to demonstrate to the Department these extenuated timeframes are consistent with good professional practice in ASD care as required by Rule 1300.67.2.2(c)(1). The Plan also provided no documentation these process issues were identified during the survey review period or that appropriate corrective actions were taken to ensure enrollees received timely ASD evaluations and treatment.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan disagreed with this finding and stated the "finding includes erroneous factual information, and fails to appreciate the clinical basis for TPMG's former process. Moreover, the preliminary finding is based on aspects of the former process that are no longer used."

The Plan described its "current Behavioral Health Treatment (BHT) Process (also known as 'Autism Initial Assessment Service')" as:

- Evaluation/Diagnosis
    - Within 10 days of referral, a licensed therapist conducts an initial

[56] *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019 ASD Program report, page 1.
[57] TPMG originally required staff to offer an appointment for an in-person evaluation within 30 calendar days of receipt of a completed parent packet. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019. The Department found evidence to suggest TPMG changed this timeframe to 60 days from receipt of the request in 2020. See *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 19, 2020, page 6. As described in Footnote 55, it is unclear if commercial enrollees are offered an in-person ASD evaluation if TPMG is not in receipt of the completed parent packet.
[58] *Behavioral Health Quality Oversight Committee* Meeting Minutes, August 21, 2019.
[59] The Department's findings are specific to delivery of ASD services. However, if the Plan and/or its delegates maintain similar processes applicable to treatment of other MH/SUD conditions, the Department requires the Plan identify those processes and describe how the Plan will ensure compliance with the statutory and regulatory requirements identified in this deficiency.

diagnostic assessment. This is a video appointment to gather clinical information from the family to: (1) determine which neurodevelopmental batteries should be administered; (2) screen for risk and readiness for the evaluation; (3) provide clinical support and case management; and (4) coordinate with ASD centers or contracted providers to complete additional neurodevelopmental testing;

- Following the initial diagnostic assessment, a licensed psychologist conducts an in-person evaluation. At this appointment, additional neurodevelopmental testing is completed, and if appropriate an ASD diagnosis is confirmed. A physician may also be involved in the evaluation to confirm any differential diagnosis or medical conditions that require physician follow-up; and

- Within five days after confirmation of the diagnosis, a therapist conducts a case management appointment. This appointment includes a discussion with families to ensure their understanding of treatment recommendations. The case is then referred to the Pediatric Developmental Care Coordination Program (PDCP).

- PDCP Process

  - Within 1-2 business days after referral, the order is reviewed for completeness, and to confirm the diagnosis in the patient's chart. A care coordinator (licensed mental health provider) is assigned at this time.

  - Within 1 business day after assignment, the care coordinator reaches out to the family to: (1) answer questions about the diagnosis; (2) discuss patient needs; (3) provide resources and information (e.g., referrals to Regional Center, school information); (4) explain the [BHT] assessment process, including how long the process may take and what to expect; (5) explain the importance of the parent/caregiver in BHT; (6) confirm parent/caregiver interest in proceeding with BHT; and (7) enter a request for assessment. If initial outreach is unsuccessful, the care coordinator makes at least four attempts (using different modes of communication and at different times). The care coordinator follows up the initial outreach discussion with a letter (the "RISP letter").

  - As soon as a parent/caregiver agrees to the BHT assessment referral (i.e., within one business day), the Plan issues a BHT assessment authorization and refers the case to outside vendor, Catalight Care Services (CCS). The BHT assessment authorization is confirmed in an authorization letter sent to the parent/caregiver (the "OMS letter").

- Parents are offered an appointment for the initial BHT Treatment Assessment (step 1) within 10 business days of the authorization start date. The initial intake assessment is conducted by a licensed clinician, and ordinarily takes about 1 or 2 hours. During this appointment, the team focuses on identifying targets for treatment. The appointment also includes treatment interventions, including providing parents/caregivers with resources, skills, and strategies to implement with their child immediately.

- Parents are offered the first appointment in the Treatment Specific Assessment process (step 2) within 10 business days of the initial BHT Treatment Assessment. The Treatment Specific Assessment includes multiple appointments (the process ordinarily takes a total of 6 to 8 hours). Each appointment is offered within 10 business days of the previous appointment. The goal of the Specific Treatment Assessment is to create a treatment plan for the next six months. However, the Treatment Specific Assessment is itself part of the treatment process, and is considered a professional standard for the development of an ABA/BHT program.

- BHT Treatment begins after completion of the Treatment Specific Assessment, with the first treatment appointment offered within 10 business days of completion.

The Plan indicated “the deficiency will be addressed in the CAWP in connection with Corrective Action Area Number 8: Continuous Detail & Comprehensive Review.”

Supporting Documentation:

- Kaiser Foundation Health Plan’s Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 7: TPMG Workflow for ASD (October 18, 2024)
- Exhibit 8: RISP Letter (October 18, 2024)
- Exhibit 9: OMS Letter (October 18, 2024)
- Exhibit 10: Maston & Goldin, *Early Intensive Behavioral Interventions: Selecting behaviors for treatment and assessing treatment effectiveness* (November 21, 2023)
- Exhibit 11: Gould, Dixon, Najdowski, Smith & Tarbox, *A review of assessments for determining the content of early intensive behavioral intervention programs for autism spectrum disorders* (January 15, 2011)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed and undertaken, the Department has determined this deficiency is not corrected.

The Department did not find “TPMG’s former process required enrollees to wait up to four months before receiving ASD treatment services” as asserted by the Plan. Rather,

the Department observed TPMG required enrollees seeking ASD services to participate in a multi-step administrative process that could result in enrollees waiting up to eight weeks before receiving an ASD evaluation and diagnosis, far exceeding the requirement to offer an appointment within 10 business days of request for services set forth in Section 1367.03(a)(5)(E) and Rule 1300.67.2.2(c)(5)(E).

Additionally, the Department does not dispute treatment plans for enrollees with ASD "cannot be completed in a single visit." The Department's findings did not address the adequacy of the treatment plans themselves. Instead, the Department determined the administrative processes utilized by TPMG to initiate treatment planning fails to ensure enrollees access to covered services in a timely manner consistent with good professional practice. As summarized above, TPMG allows staff to delay the enrollee's first appointment up to six weeks after completion their in-person ASD evaluation, far exceeding the 10-business day requirement set forth in Section 1367.03(a)(5)(E) and Rule 1300.67.2.2(c)(5)(E).

The Department acknowledges the Plan submitted evidence TPMG implemented changes to its system for delivering ASD services. Based on the information provided, it is unclear if TPMG's process ensures enrollees can access ASD services in a timely manner consistent with good professional practice. TPMG does not establish a timeframe for when a licensed psychologist must conduct the in-person evaluation following the enrollee's initial diagnostic assessment.

Further, it is also unclear to the Department if the remedial measures outlined in Corrective Action Area No. 8: Continuous Detail & Comprehensive Review of the Plan's CAWP are likely to correct this deficiency. The Department acknowledges Area No. 8 includes broad commitments to "engage in a systemic evaluation of all existing programs, processes, and policies and procedures by which enrollee's access or receive behavioral health services." However, the CAWP does not describe what efforts, if any, the Plan will undertake to ensure enrollees are able to access ASD services in a timely manner consistent with good professional practice as required by Section 1367.03(a)(2) and Rule 1300.67.2.2(c)(2).

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #6: The Plan does not maintain an adequate system to document external provider referrals and monitor the follow-up of enrollees' health care documentation to ensure services are furnished in a timely and appropriate manner.

Statutory and Regulatory References: Section 1367(d); Rule 1300.67.1(d)-(e).

Assessment: Rule 1300.67.1(e) requires the Plan to provide an adequate system of documentation of referrals to physicians or other health professionals and monitor the follow-up of enrollees' health care documentation. Section 1367(d) mandates the Plan

to furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice. Rule 1300.67.1(d) requires the Plan to ensure continuity of care by maintaining sufficient health professionals, administrative, and other supporting staff to assure that health care services will be provided on a timely and appropriate basis to enrollees.

The Department reviewed 71 TPMG AR 1 files, 70 TPMG AR 2 files, and 71 TPMG AR 3 files. Of these files, four TPMG AR 1 files,[60] six TPMG AR 2 files,[61] and nine TPMG AR 3 files[62] contained evidence TPMG referred enrollees to external providers.[63] However, none of these files included medical records from these providers. There was no evidence TPMG or the Plan made any efforts to confirm enrollees were able to access external provider services in a timely and appropriate manner. Several files included evidence enrollees made repeated attempts to schedule appointments with external providers without success. Further, file review revealed instances in which enrollees were likely lost to follow-up without documented provision of care.

Case Examples

- **DMHC TPMG AR 1 File 21:** On March 12, 2021, the enrollee completed an initial assessment and was referred to an external provider for treatment of Depression and Anxiety.

  On January 10, 2022, the enrollee completed a medication evaluation intake appointment. After the appointment, the TPMG psychiatrist sent a message to the enrollee referencing treatment by an external provider: “I know that you are seeing an out of network therapist, and working primarily with her.” This reference was the only documentation in the file indicating the enrollee was receiving services from an external provider.[64]

  This file is deficient because the Plan failed to maintain an adequate system to document the enrollee’s external provider referral and monitor the follow-up of the enrollee’s documentation to ensure services are furnished in a timely and appropriate manner.

[60] DMHC TPMG AR 1 Files 1, 21, 47, 56.
[61] DMHC TPMG AR 2 Files 35, 37, 45, 49, 53, 57.
[62] DMHC TPMG AR 3 Files 1, 19, 39, 43, 50, 51, 57, 60, 65.
[63] All references to “external provider” in this report include external contracted providers and/or OON providers.
[64] Evidence in the file suggests the enrollee was unable to access services from the external provider for several months. On April 12, 2021, the enrollee contacted TPMG indicating she was still waiting for instructions on scheduling an appointment with the external provider four weeks after receiving the referral. On August 26, 2021, a TPMG provider documented the enrollee stated she has been “trying to find a therapist since December [2020]…[S]he called all the people on the list but only one [external provider] had an opening and [the external provider did not] feel comfortable taking [the coverage].” The TPMG provider documented this conversation with the enrollee more than five months after the enrollee received the referral to an external provider. DMHC TPMG AR 1 File 21, pages 15-16, 18.

- **DMHC TPMG AR 2 File 49:** On July 17, 2020, the enrollee completed an initial assessment and was referred to an external provider for treatment of Anxiety and Depression. The referral included both individual therapy and medication evaluation.

  There is no evidence demonstrating the enrollee received services from the external provider. In addition, the enrollee made four complaints expressing dissatisfaction with his inability to access individual therapy services from the external provider.[65] The enrollee was unable to access care with the external provider for over a year and his condition worsened. During an appointment on August 3, 2021, a TPMG therapist recommended a higher level of care and noted, "Patient's level of depression is so severe that he is unable to complete work assignment and has needed to take time away from work. He is barely able to complete [Activities of Daily Living] at home."

  This file is deficient because the Plan failed to maintain an adequate system to document the enrollee's external provider referral and monitor the follow-up of the enrollee's documentation to ensure services are furnished in a timely and appropriate manner.

- **DMHC TPMG AR 3 File 19:** On September 10, 2019, the enrollee completed a triage appointment for symptoms of "anxiety and depression...with insomnia, low energy and poor concentration." During the triage appointment, the enrollee requested a referral "for outside therapy."

  During an intake evaluation with a TPMG psychiatrist on October 7, 2019, the enrollee again requested an "outside therapy referral." An external provider referral request was submitted and approved on October 9, 2019. The enrollee was informed and provided with the external provider's telephone number.

  Over four months after the enrollee requested a referral, he was still unable to access individual therapy services with an external provider. On January 28, 2020, the enrollee attended an initial assessment appointment with a TPMG therapist. The TPMG therapist noted: "[The enrollee] has been trying to link to [the external provider] for [treatment] but has not had success. He decided to start therapy at [K]aiser, while looking for a therapist for weekly, bi-weekly therapy."

  On February 10, 2021, the enrollee again requested an "outside referral" due to "dissatisfaction with frequency of meetings" held with the TPMG therapist. There was no evidence of a response to the enrollee's request in the medical records. On March 9, 2021, the enrollee sent a message to the TPMG therapist to follow-up on the status of his February request. On March 15, 2021, a TPMG clinic manager sent the enrollee a copy of another approved referral to an external provider.

[65] July 29, 2020, August 12, 2020, September 16, 2020, August 3, 2021.

> Following this second approved referral, the enrollee contacted TPMG five more times because he was still unable to access therapy from an external provider.[66] The enrollee's last documented contact with TPMG was on January 28, 2022. Although over 28 months elapsed between the enrollee's initial request for outside therapy on September 10, 2019, the file contained no evidence the enrollee obtained an appointment with an external provider.
>
> This file is deficient because the Plan failed to maintain an adequate system to document the enrollee's external provider referral and monitor the follow-up of the enrollee's documentation to ensure services are furnished in a timely and appropriate manner.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> Some of the Department's summaries of the records are inaccurate and/or incomplete; the records do contain evidence that TPMG endeavored to monitor and document care by external providers after referrals. Nonetheless, the Plan acknowledges the opportunity for improvement and the Settlement Agreement and CAWP address this issue.

The Plan asserted all corrective actions required to remediate this deficiency are "incorporated into the CAWP in connection with Corrective Action Area No. 3: Network & Referrals." The Plan indicated it had "begun the process for improving its system for documenting external provider referrals and monitoring the follow-up of enrollees' health care documentation."

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 1: Settlement Agreement (October 11, 2023)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

The Plan failed to submit evidence to support its assertion that "[s]ome of the Department's summaries of the records are inaccurate and/or incomplete" and "the records do contain evidence that TPMG endeavored to monitor and document care by external providers after referrals."

[66] December 1, 2021, January 3, 2022, January 13, 2022, January 27, 2022, January 28, 2022.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #7: The Plan does not maintain medical records in a manner which provides continuity of care.

Regulatory Reference: Rule 1300.67.1(c).

Assessment: Rule 1300.67.1 requires the Plan to provide services in a manner which provides continuity of care. As part of this requirement, Rule 1300.67.1(c) mandates the Plan to ensure medical records are maintained and readily available with sharing within the Plan of all pertinent information relating to the health care of each enrollee.

The Plan's provider manual outlines required medical record standards applicable to all contracted providers.[67,68] The provider manual also recommends "all Providers maintain their medical records following standards applicable to their specialty to assure the consistency and completeness of patient medical records."[69]

The Department reviewed 71 TPMG AR 1 files, 70 TPMG AR 2 files, and 71 TPMG AR 3 files. None of the files reviewed included sufficient documentation to demonstrate medical records are maintained and readily available in a manner which provides continuity of care. Medical records were frequently incomplete or missing pertinent documentation of the initial treatment request,[70] triage,[71] and intake.[72] In addition, there were discrepancies between appointment records and clinical treatment notes.[73]

The Department also identified eight TPMG AR 1 files, nine TPMG AR 2 files, and nine TPMG AR 3 files included documentation indicating enrollees were referred to external

[67] *Northern California HMO Provider Manual Kaiser Foundation Health Plan, Inc.*, pages 123-126.
[68] Contracted providers are responsible for ensuring its subcontractors comply with all applicable provisions of the provider manual. *Id*., page 2.
[69] *Id*., page 136.
[70] DMHC TPMG AR 1 Files 1-5, 7-12, 14, 16-20, 22, 23, 25, 27, 29, 31-33, 35, 37, 38, 40, 42-46, 48-52, 55, 57-67, 69-71. DMHC TPMG AR 2 Files 1-8, 10-17, 19-28, 30-32, 38, 39, 41-44, 48-62, 64, 65, 67, 68, 70, 71. DMHC TPMG AR 3 Files 1-3, 8-10, 12, 13, 21, 22, 24-26, 29, 31, 34, 35, 37-40, 42-44, 48-60, 63, 66, 70, 71.
[71] DMHC TPMG AR 1 Files 9, 17, 19, 22, 33, 38, 43, 44, 49, 50, 52, 55, 59, 65, 66, 71. DMHC TPMG AR 2 Files 4, 7, 10, 12, 13, 22, 24, 26-28, 32, 35, 38, 44, 52, 55, 58, 60, 61, 67, 70. DMHC TPMG AR 3 Files 2, 3, 8, 10, 13, 21, 23-25, 27-29, 31, 34, 35, 42, 50-55, 58, 63, 66, 70, 71.
[72] DMHC TPMG AR 1 Files 17, 22, 38, 44, 49, 52, 54, 55, 59, 66, 71. DMHC TPMG AR 2 Files 3, 4, 7, 10, 12, 13, 24, 27-29, 31, 44, 52, 54, 58, 61, 67, 70. DMHC TPMG AR 3 Files 2, 3, 8, 10, 13, 21, 26, 29-31, 34, 35, 42, 50, 52, 54, 55, 63, 66, 71.
[73] DMHC TPMG AR 1 Files 1, 3, 5, 6, 8, 11, 13, 18-21, 23-32, 34-36, 38-45, 47-52, 54, 56, 57, 63-71. DMHC TPMG AR 2 Files 1-7, 10-17, 19-22, 24, 26-28, 31, 32, 35, 37, 39, 40, 43-48, 50, 54-61, 64, 65, 67, 70. DMHC TPMG AR 3 Files 1-7, 10-17, 19-22, 24, 26-28, 31, 32, 35, 37, 39, 40, 43-48, 50, 54-61, 64, 65, 67, 70.

providers.[74] None of these files contained medical records documenting pertinent information about what care, if any, the enrollees received from the external providers.

Case Examples

- **DMHC TPMG AR 1 File 35:** The enrollee's medical records failed to include documentation of the initial request for treatment.

  Appointment records indicated the enrollee completed a telephone visit with a medical doctor on June 14, 2021. However, there was no corresponding chart documentation from the provider within the enrollee's medical records. Appointment records also documented two no show appointments and one completed telephone visit with another medical doctor on June 25, 2021. Corresponding chart documentation for these three appointments was not found in the enrollee's medical records.

  This file is deficient because the Plan and TPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care.

- **DMHC TPMG AR 2 File 17:** The enrollee's medical records failed to include documentation of the initial request for treatment.

  The LCSW's chart documentation contained insufficient details about the enrollee's care. The LCSW failed to personalize the notes in some sections and omitted major elements of chart documentation. For example, medical records state, "*** is a *** who returns for *** therapy. *** reports the following..." The quoted language included asterisks in place of key clinical information, such as the enrollee's name and diagnosis.

  Furthermore, the LCSW consistently failed to document care in a timely manner.[75] Appointment records indicate the LCSW saw the enrollee on September 4, 2019, September 24, 2019, and October 15, 2019, but delayed documenting these visits in the enrollee's medical records until November 11, 2019, November 24, 2019, and November 24, 2019, respectively. The provider's failure to document care in a timely manner could have impeded appropriate continuity of care if the enrollee needed interim care. Further, as more time elapses between a treatment appointment and its corresponding chart documentation, the clinician is forced to rely on potentially fading memory and risks entering potentially inaccurate information into the enrollee's medical records.

[74] DMHC TPMG AR 1 Files 1, 9, 21, 24, 33, 47, 56, 57. DMHC TPMG AR 2 Files 1, 30, 35, 37, 45, 48, 49, 53, 71. DMHC TPMG AR 3 Files 1, 19, 39, 42, 50, 51, 57, 60, 65.
[75] The Plan's medical records standards require all notes and entries "[a]re done in a timely manner." *Northern California HMO Provider Manual Kaiser Foundation Health Plan, Inc.*, page 124.

This file is deficient because the Plan and TPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care. Further, the provider did not comply with the Plan's medical records standards requiring all notes and entries to be documented in a timely manner.

- **DMHC TPMG AR 3 File 26:** The enrollee was receiving medication and case management services. The enrollee's medical records failed to include documentation of the initial request for treatment, triage, and intake assessment.

  Appointment records indicate TPMG providers scheduled 11 appointments with the enrollee between January 2020 through November 2021. However, there was no corresponding chart documentation for any of these appointments within the enrollee's medical records.

  This file is deficient because the Plan and TPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> The Plan does not agree with the finding. The Medical Groups maintain patients' medical records using state-of-the-art software and technology. That software and technology is designed to enable ready sharing of an enrollee's records within the Plan. However, medical records are relatively complex, and contain large amounts of data. The Plan *compiled* information from the medical records in an effort to fully respond to the Department's requests in connection with the Survey. However, the Plan did not produce the *entire* medical records of its enrollees. As such, the files the Plan produced in response to the Department's requests did not include all of the information that exists in the medical records. To the extent the Department has identified gaps in the medical records, or discrepancies between appointment records and clinical treatment notes, that is not because the record is incomplete, but rather because the files in the Department's possession represent only a portion of the complete record.

The Plan indicated it reviewed the Department's case examples and was able to locate some of the missing documentation with the enrollee's complete medical records, stating:

> …[W]ith respect to TPMG AR 1 File 35[,]…the Department determined that the record lacked documentation corresponding to a telephone visit with a medical doctor on June 14, 2021. The Plan has confirmed that documentation for that visit is present in the enrollee's complete record. This particular record simply was not included in the information compiled for production during the survey.

> With respect to TPMG AR 3 File 26[,]…the Department determined that the enrollee's medical records failed to include documentation of the initial request for treatment, triage and intake assessment. The Department also determined that the file lacked chart documentation corresponding to eleven appointments with the enrollee between January 2020 through November 2021. The complete record, however, shows the patient had been receiving care since 2007, so any "initial request" for treatment would have been outside the survey period. The record also contains chart documentation for at least 16 appointments during the January 2020 through November 2021 timeframe.

The Plan acknowledged "some gaps in the chart documentation may result from failures by individual providers to fully comply with medical record standards," but asserted it "has systems in place designed to maximize compliance with standards–including training, monitoring and quality audits."

Finally, the Plan asserted it "does not agree that corrective action is necessary" and it "has not engaged in efforts to modify its record-keeping processes." To the extent the Final Report maintains this finding, the Plan indicated any corrective action will be addressed in the CAWP under Corrective Action Area No. 2: Access.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 12: Additional Record TPMG AR 1 File 35 (October 18, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed, the Department has determined this deficiency is not corrected.

During the Nonroutine Survey, the Department requested the Plan submit the following records for each case file selected for review:

> **Behavioral Health/Mental Health/Substance Use Disorder (BH/MH/SUD) Appointments**
> For each case file, provide the requested information listed below as a single PDF. To assist efficiency of review, please bookmark the PDF document. Please title the bookmarks as follows:
>
> 1. File ID #
> 2. The appointment selected by the Department
> 3. Each individual BH/MH/SUD appointment
> 4. Any communications between staff and providers (internal and external), including but not limited to, communications in Microsoft Teams
> 5. Amendments to medical records and notes after initial submission

File contents must include all medical records, plan and provider notes or comments, internal and external communications, screen prints and all other documentation showing the enrollee's case of care including the initial request for BH/MH/SUD services, triage, and any subsequent requests for BH/MH/SUD services. The file should contain all BH/MH/SUD appointments for the selected enrollee in chronological order.

All files must include the following:

- File ID # (Plan's unique case identification number)
- Line of business (Individual, Small Group, Large Group or Medi-Cal)
- Name of enrollee, if applicable
- Enrollee ID #, if applicable
- Name of enrollee's assigned service area/medical center or other delegated entity, if applicable
- Enrollee's initial contact requesting MH/BH/SUD services. If the enrollee is referred by a provider, include the referral
- Enrollee's triage appointment
- Enrollee's intake appointment
- Any subsequent MH/BH/SUD appointments
- Any subsequent contact from the enrollee or their provider requesting MH/BH/SUD services.
- Legend for each code or value contained in screen prints or other documentation provided

The Plan failed to inform the Department it only "produced excerpts from medical records" in response to the Department's above request. The Plan also failed to inform the Department it did not produce records documenting the enrollee's initial request for MH/SUD services if it occurred outside the survey review period.

The Plan did not produce evidence to support its assertion that, "[t]o the extent the Department has identified gaps in the medical records, or discrepancies between appointment records and clinical treatment notes, that is not because the record is incomplete, but rather because the files in the Department's possession represent only a portion of the complete record." Further, the Department determined the limited documentation submitted by the Plan in response to the Department's case examples did not alter its initial findings:

- **TPMG AR 1 File 35:** The Department acknowledges the Plan produced chart documentation for the enrollee's appointment on June 14, 2021. The Plan admits it did not produce this record during the Department's Nonroutine Survey as originally requested. The Plan failed to produce any documentation showing it maintained records of the enrollee's initial request for services and chart documentation corresponding with the enrollee's appointment on June 25, 2021. Without such evidence, the Department find the file remains deficient.

- **TPMG AR 3 File 26:** The Plan stated the enrollee was receiving care since 2007, therefore "any 'initial request' for treatment would have been outside the survey period." The Plan also asserts its records contain "chart documentation for at least 16 appointments during the January 2020 through November 2021 timeframe." However, the Plan failed to provide any evidence to support these statements. Without such evidence, the Department finds the file remains deficient.

In addition, it is also unclear to the Department if the remedial measures outlined in Corrective Action Area No. 2: Access of the Plan's CAWP are likely to correct this deficiency. The Department acknowledges Area No. 2 includes a commitment to develop improved policy and process to ensure providers:

> [F]ully document in the enrollees' medical records the date and time the enrollee requested behavioral health appointments, the date and time of the first available appointment that was offered to the enrollee, the date and time of the appointment the enrollee accepted, and if a statement of non-detriment or patient preference is documented in the enrollee's medical record.

However, the CAWP does not address what, if any, efforts the Plan will undertake to ensure medical records are maintained and readily available with sharing within the Plan of all pertinent information relating to the health care of each enrollee, as required by Rule 1300.67.1(c). This includes documentation of intake, triage, and clinical treatment notes, which are not addressed in the Plan's CAWP.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #8: The Plan fails to monitor and take effective action to correct identified access issues.

Statutory and Regulatory References: Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1); Rule 1300.70(a)(1), (3), (b)(1)(B).

Assessment: Section 1367.03(a)(1) and Rule 1300.67.2.2(c)(1) require the Plan to establish and maintain QA monitoring systems and processes sufficient to ensure services are provided in a manner consistent with good professional practice and in compliance with applicable timely access standards. Rule 1300.70(a)(3) similarly mandates the Plan's QA program to address accessibility and availability of care. Rule 1300.70(a)(1) and (b)(1)(B) require the Plan to take effective action to correct problems identified by its QA program.

The Plan's *Oversight & Monitoring for Access and Availability* policy describes its timely access monitoring process.[76] The policy states the Plan provides "oversight and monitoring of: ...Reviewing corrective action plans when oversight, monitoring, and/or auditing activities discloses that the Health Plan's Provider Network is insufficient to ensure timely access and availability."[77]

The policy also outlines an escalation process "when access to appointments or provider network availability is insufficient to meet member needs."[78] If access and availability standards are below established benchmarks in Northern California, each Service Area Manager and Physician-in-Chief must submit an action plan to the Access Committee.[79] If the action plan fails to remediate the identified access issue, then the Access Committee must "develop additional actions for implementation by a service or medical center area."[80]

TPMG's *Timeliness of Access – Initiate to Seen* (ITS) reports assess all new requests for MH/SUD services received each month for compliance with timely access standards. The ITS reports measure compliance for each service area and each county in NCAL against its "initiate to seen" standard.[81] All service areas and counties are required to achieve at least 80 percent compliance with applicable timely access standards.[82] The reports are generated and reviewed by the Access Committee on a monthly basis.

In each ITS report, with the exception of the February 2022 report, at least one service area or county fell below the required 80 percent compliance threshold.[83] Despite this finding, the Access Committee only initiated corrective actions to remediate access compliance issues identified in meeting minutes from May 2019 through September 2019.[84]

The Access Committee included the following statement in each set of minutes generated from October 2019 onward: "The Access Committee's established action is to request corrective action plans from all service areas with access below the threshold for review for two or more consecutive months. No actions required based on current performances." The Department determined this established action is inconsistent with the requirement to continuously review the quality of care provided and take effective corrective action to resolve identified access issues, as set forth in Rule

[76] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 1.
[77] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[78] *Id*.
[79] *Id*.
[80] *Id*., pages 3-4.
[81] The Department was unable to locate any documentation of the methodology used by TPMG or the Plan to generate these reports. Specifically, the Department found no evidence describing how "initiate" is defined for the purposes of measuring compliance with its "initiate to seen" standard. It is unclear whether these monitoring efforts allow TPMG and the Plan to assess time-elapsed based on receipt of the initial request for MH/SUD services by the enrollee, consistent with the appointment wait time definition in Rule 1300.67.2.2(b)(2). The Department also observes TPMG and the Plan failed to consistently document initial requests for MH/SUD services in its medical records, as described in Deficiency #7.
[82] *KP NCAL Access Committee* Meeting Minutes, May 28, 2019, page 2.
[83] *KP NCAL Access Committee* Meeting Minutes, May 28, 2019 through February 22, 2022 and April 26, 2022.
[84] *KP NCAL Access Committee* Meeting Minutes, May 28, 2019 through September 24, 2019.

1300.70(b)(1)(B). This practice also conflicts with the *Oversight & Monitoring for Access and Availability* policy, which requires each Service Area Manager and Physician-in-Chief to submit an action plan to the Access Committee if access and availability fall below established benchmarks.[85]

Although TPMG contracts with hundreds of external provider groups and individual providers, the Access Committee only monitored Beacon Health and Magellan and failed to monitor the timeliness of new appointments provided by other external contracted providers. The Access Committee failed to initiate remedial measures in instances where Beacon Health did not achieve 80 percent compliance for two or more consecutive months. For example, in January 2021 through August 2021, four service areas fell below the 80 percent threshold in two or more consecutive months.[86] However, there was no evidence any corrective action plans were submitted.

Furthermore, the ITS reports do not include new appointment data for OON providers. TPMG and the Plan did not provide evidence to demonstrate an adequate QA monitoring system and process was established and maintained to ensure new MH/SUD appointments with external providers are provided in a manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated it:

> …respectfully disagrees with the Department's legal interpretation for several reasons. First, Rule 1300.70(b)(1)(B) requires that the Plan's quality assurance program be designed to ensure that quality of care problems are identified and corrected. It does not dictate particular means or specific timetables for identifying and correcting quality of care problems. The Plan's established 2-consecutive-month standard for triggering a formal corrective action plan satisfies that requirement. As the ITS reports demonstrate, each service area must track and report its compliance with the access standard on a monthly basis. The Access Committee's "established action" gives leaders in the service area both an opportunity and the incentive to make voluntary course corrections to improve performance quickly and avoid formal corrective action.
>
> Notably, the fact that a service area or county falls below the compliance threshold in a single month does not necessarily indicate a need for remedial action or major changes. Indeed, a one-month snapshot may inaccurately suggest the need for corrective action where no need exists. For example, where an unanticipated illness or provider absence created a short-term gap. As explained above, improved performance may be achieved with simple course corrections under the direction of local leadership. On the other hand, a shortfall in two consecutive months does indicate that more formal intervention is warranted. In those instances, the requirement for formal corrective action plans ensures that necessary

[85] *Oversight & Monitoring for Access and Availability* (Northern California Region), page 3.
[86] The four service areas are Diablo, East Bay, North Valley, and South Sacramento.

> steps are taken to correct the identified problem. As such, the 2-consecutive-month standard is designed to promote the identification and correction of access issues as quickly as possible.
>
> There is no conflict between the Access Committee's 2-consecutive-month standard and the Plan's *Oversight & Monitoring for Access and Availability Policy.* While the policy requires Service Area Managers and Physicians-in-Chief to submit action plans if access and availability fall below established benchmarks, it does not dictate any specific criteria for *when* the Access Committee must deem a service area to have fallen below the benchmark for purposes of requiring a formal action plan.
>
> Finally, at the time of the Survey, the 2-consecutive-month standard had been established and followed for many years. While the Plan has been unable to identify specific documentation wherein the Department expressly approved that standard, the Plan is informed and believes the Department was previously aware of it, and had never suggested the Plan's use of the standard was noncompliant with regulatory requirements. The Plan requests that the [F]inal [R]eport exclude any survey information, legal findings, or conclusions that the Plan violated the statutory or regulatory requirements due to the Access Committee's established action of requiring a corrective action plan where a service area or county falls below the compliance threshold for [two] or more consecutive months.

The Plan acknowledged:

- The Access Committee failed to monitor the timeliness of new appointments provided by external contracted providers other than Beacon Health and Magellan

- The Access Committee failed to initiate remedial measures in instances where Beacon Health did not achieve 80 percent compliance for two or more consecutive months

- ITS reports do not include new appointment data for [OON] providers.

Finally, the Plan requested "the [F]inal [R]eport exclude the erroneous legal findings and conclusions." However, the Plan indicated it "has begun the process for improving its system for monitoring and remediating timeliness of access issues with respect to external providers, as described in…[Corrective Action Area Number 2: Access].

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

The Plan's disagreement with the Department's "legal interpretation" of Rule 1300.70(b)(1)(B) is unfounded, as the Department's analysis is based on inconsistencies between the requirements set forth in the *Oversight & Monitoring for Access and Availability* policy and the Access Committee's actions. Specifically, the policy requires "each Service Area Manager and Physician-in-Chief" and/or the Access Committee to develop an action plan "when access to appointments or provider network availability is insufficient to meet member needs." The escalation process outlined in the policy is triggered "when access to appointments or provider network availability is insufficient to meet member needs," not when a service area falls below threshold for two or more consecutive months.

Although the Plan indicated "[t]here is no conflict between the Access Committee's 2-consecutive-month standard and the Plan's *Oversight & Monitoring for Access and Availability Policy*," the Plan has not demonstrated the Access Committee's standard is a reasonable process. For example, if a service area falls below standard every other month, then no action is necessary even though the service area is below standard six months out of the year. Thus, based on current practices, the Plan does not "continuously review the quality of care provided…and does not ensure that quality of care problems are identified and corrected for all provider entities," as required by Rule 1300.70(b)(1)(B).

Furthermore, while the Plan acknowledged its inadequate monitoring of the timeliness of new external provider appointments, how the "initiate to seen" standard is calculated remains unknown. Also, the Plan provided no explanation why action plans were not submitted for the four service areas that fell below the 80 percent threshold for two consecutive months in January 2021 through August 2021.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, policies and procedures, meeting minutes, interviews, and any other review deemed necessary by the Department.

Deficiency #9: The Plan does not take effective action to improve care where grievance and appeal deficiencies are identified.

Regulatory Reference: Rule 1300.70(a)(1).

Assessment: Rule 1300.70(a)(1) requires the Plan to document that the quality of care being provided is being reviewed, problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

The BHQOC evaluates the quality of behavioral health care and services provided to Kaiser Permanente Northern California members and supports continuous quality improvement of behavioral health programs.[87]

2019

The 2019 Complaints and Grievances Report stated:

> For the period January 1, 2019 to December 31, 2019, a total of 6928 Complaints and Grievances were received regarding care in the [BH] Departments…BH includes both Psychiatry and Chemical Dependency. These complaints and grievances fall into the following categories: Access to Care, Attitude and Service, Billing and Financial, and Quality of Care…[88]

The Behavioral Health Complaint, Grievance, and Appeal Medical Center Overview also included 47 appeals.[89] Appeals are defined as "grievances that have been denied and the decision has been appealed."[90] The overview provided a breakdown of the four categories of issues. Of the 7,009 complaints and grievances:[91]

- Access to Care: 2,238 (31.93%)
- Attitude and Service: 3,087 (44.04%)
- Billing and Financial: 348 (4.97%)
- Quality of Care: 1,336 (19.06%)[92]

The Behavioral Health Quality Improvement Committee (BHQIC) set a target of three complaints and grievances per 1,000 visits. Eleven medical centers exceeded the target.[93]

The BHQOC meeting minutes include a "drill-down" analysis of "complaint and grievance category and subcategories…for all Medical Centers identified as outliers." The analysis is "intended to help focus attention on where issue are for the outlier Medical Center."[94] Although 11 medical centers exceeded the target, drill-down analysis

[87] *Kaiser Permanente Northern California (KPNC) Behavioral Health Care Program Description*, page 8.
[88] *Behavioral Health Complaint and Grievance Medical Center Overview*, page 3.
[89] *Id*., page 4.
[90] *Id*.
[91] It is unknown why the total number is 7,009. Adding 6,928 complaints and grievances and 47 appeals comes out to 6,975.
[92] *Behavioral Health Complaint and Grievance Medical Center Overview*, page 5.
[93] San Francisco, Roseville, South Sacramento, Sacramento, Santa Rosa, San Rafael, Vacaville, Oakland, Richmond, Antioch, Santa Clara. *Id*., page 3.
[94] *Id*.

was only performed for the top four medical centers (San Francisco, Roseville, South Sacramento, Sacramento).[95]

There was no documentation any action was taken to correct the identified issues.

2020

The NCAL Behavioral Health Grievance Trending Report from January 1, 2020 through September 30, 2020[96] found behavioral health grievances decreased 8.73 percent "primarily driven by a reduction in access concerns during COVID and reduction in overall activity/utilization during COVID."[97]

In 2020, Billing and Financial was removed from the four categories of issues. Member Services reported the following issues to the BHQOC:

- Access issues are beginning to pop up again in July-September. During this time they made up for approximately 30 percent of grievance volume in the Behavioral Health department.[98]
- Quality of Service complaints are trending back up and are still up year over year, primarily in the area of staff Behavior and Verbal Communication.[99]
- Diagnosis Treatment of Care – Treatment Quality was the highest detailed category. There were peaks in volume late in the year in 2019, and year over year volumes have increased.[100]

While the Member Services report still calculates the average number of complaints and grievances per 1,000 encounters, numbers are not associated with each medical center as they were in 2019. Instead, the medical center data is plotted on four quadrants with no raw numbers or averages provided. The quarter 3 (Q3) 2020 report indicated "Sacramento, San Francisco and Oakland and Roseville should be reviewed as they are in the 'risk quadrant'."[101,102] San Rafael and San Jose are also in this "risk quadrant";[103] however, it is unknown why these two medical centers were not included for review. Also, it is unknown whether the BHQIC's target of three complaints and grievances per 1,000 visits is still applicable.

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[95] *Behavioral Health Complaint and Grievance Medical Center Overview*, page 8.
[96] The December 16, 2020 *Behavioral Health Quality Oversight Committee* Meeting Minutes only provided data from the first three quarters of 2020. The next BHQOC meeting, scheduled on February 17, 2021 should have included a comprehensive analysis of the 2020 behavioral health grievance data. However, this information was not included in the February 17, 2021 *Behavioral Health Quality Oversight Committee* Meeting Minutes.
[97] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (October 28, 2020), page 2.
[98] *Id*., page 4.
[99] *Id*., page 5.
[100] *Id*., page 6.
[101] The "risk quadrant" is the upper right quadrant. It includes the medical centers with the highest distinct issue count (x-axis) and the most issues per 1,000 encounters (y-axis).
[102] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (October 28, 2020), page 8.
[103] *Id*.

There was no documentation any action was taken to correct the identified issues.

2021

The NCAL Behavioral Health Grievance Trending Report from January 1, 2021 through December 31, 2021 found behavioral health grievances increased 37 percent.[104] In addition, Behavioral Health now ranked second in total issues year-to-date across all NCAL Departments.[105]

In 2021, the following issues were reported to the BHQOC in the three categories:

- Access issues decreased slowly beginning August 2021. Most complaints are relative to being unable to schedule timely appointments, but there are also increases in complaints related to appointment cancellations.[106]
- Quality of Service issues are up and down but peaked in September. Most complaints are relative to behavior from staff.[107]
- Quality of Care issues have not increased with the same velocity as the other categories. However, when reading through complaints, many of the concerns discuss members feeling like they are not getting the care they need or displeased with their treatment plan.[108]

The 2021 Member Services report indicated "San Francisco, Sacramento, Oakland, and Roseville should be reviewed as they are in the 'risk quadrant'."[109] These same four medical centers were previously identified in the Q3 2020 report.

Of all the medical centers identified in the "risk quadrant," Oakland was the only medical center associated with any, albeit ambiguous, corrective action:

> The Oakland Behavioral Health department was identified as an outlier for volume of member complaints and grievances in 2019. Oakland continued to have a high number of complaints compared to most other medical centers over the following two years. Oakland shared a trend for almost all medical centers behavioral health of significantly rising complaints. ~80% of these complaints are thought to be related to real issues with access to therapy services. Oakland has made some progress with hiring and new workflows.[110]
>
> The only other documented action was, "As a next step, the BHQOC will hear from the sites with the most volume of grievances/complaints

[104] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (February 10, 2022), page 2.
[105] *Id*., page 3.
[106] *Id*., page 4.
[107] *Id*., page 5.
[108] *Id*., page 6.
[109] *Id*., page 7.
[110] *Behavioral Health Quality Oversight Committee* Meeting Minutes, December 15, 2021, page 3.

this year."[111] It is unclear how this would be an appropriate solution to address the identified grievance issues.

The BHQOC meeting minutes demonstrated the Plan had been aware of the enrollees' increasing frustrations with the lack of available appointments, communication difficulties with Plan staff, challenges of navigating the Plan's system, and the poor quality of care received. Nevertheless, the number of behavioral health grievances steadily increased for years.

- 2017: 3,459 behavioral health complaints and grievances[112]
- 2018: 4,517 behavioral health complaints and grievances (31 percent increase)[113]
- 2019: 6,975 behavioral health complaints and grievances (54 percent increase)[114]
- 2020: No raw number available (9 percent decrease due to COVID)[115]
- 2021: No raw number available (37 percent increase)[116]

From 2020 to 2021, the total number of behavioral health issues went from ranking fourth to second across all NCAL Departments. As the same grievance issues and medical centers are identified and reported on year after year, there is no documented evidence the BHQOC, TPMG, or the Plan took effective action to address identified access and quality grievances.

The areas for continued improvement identified in reports presented to the BHQOC over the review period are as follows:

[111] *Behavioral Health Quality Oversight Committee* Meeting Minutes, February 16, 2022, page 3.
[112] *Behavioral Health Complaint and Grievance Medical Center Overview*, page 6.
[113] *Id*.
[114] *Id*.
[115] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (October 28, 2020), page 2.
[116] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (February 10, 2022), page 2.

	2020[117]	2021[118]	2022[119]
Access/ Referrals	Members expressed a high level of frustration in their experience with spending a lot of time trying to navigate the system and not getting the outcome they expect/desire. Members feel that KP makes it difficult to impossible to [sic] receive care with network providers when access is unavailable at KP, which contributes to negative outcomes in their mental health.	Members have difficulty navigating the system and do not get the outcome they expect/desire.	Members have expressed a high level of frustration in their experience with spending a lot of time trying to navigate the system and not getting the outcome they expect/desire.
		Members are asked to wait weeks or months at a time for appointment availability.	Members are asked to wait weeks or months at a time for in-person appointment availability.
		Return appointment access and overall availability with limitations in access among external contracted providers.	

[117] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (October 28, 2020), page 2.
[118] *Behavioral Health Quality Oversight Committee* Meeting Minutes, December 15, 2021.
[119] *HPPSA Health Plan Member Services NCAL – Grievance Trending – Behavioral Health Focused Analysis* (February 10, 2022), page 2.

			Routine appointment access and overall availability is also an area of concern with referred providers. Members are very frustrated that it takes such a long time to get a referral and then when they finally do, network providers are unavailable. This is delaying care for several months even for members in dire situations.
Quality of Service	Primary area of member dissatisfaction concerns not receiving call backs when they are given direction to await follow-up. In some cases, members tried multiple times to connect with no success.	Primary area of member dissatisfaction concerns not receiving call backs. In some cases, members tried multiple times to connect with no success.	Primary area of member dissatisfaction concerns not receiving call backs when they are given direction to await follow-up. In some cases, members tried multiple times to connect with no success.
		Members are spending a significant amount of time calling for appointments, referral status, form signoff, etc.	Members are highly frustrated with how much time they are being asked to spend calling for appointments, referral status, form signoff, etc.
Quality of Care	Members perceived that providers are not willing to have open and collaborative discussions about medication.		
		Members do not feel like KP takes their mental health seriously and perceive a lack of empathy from providers.	Members do not feel like KP takes their mental health seriously and perceive a lack of empathy from providers.

	Many members were highly frustrated with perceived care gaps due to lack of regular/reliable communication from Kaiser as described above.	Many members perceive care gaps due to lack of regular/reliable communication from Kaiser as described above.	Many members were highly frustrated with perceived care gaps due to lack of regular/reliable communication from Kaiser as described above.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated the Department's "finding was included in and addressed in connection with the CAWP as part of Corrective Action Area Number 4: Grievances and Appeals." Additionally:

> …the Plan agreed to improve its grievance and appeals policies and procedures, and to implement corrective actions as outlined in the Settlement Agreement…The Plan has been working with the Consulting Team to identify actions to improve performance in this area.

The Plan indicated it launched its California Member Relations Grievance Operations Behavioral Health Decision Making Committee in September 2022. The Plan explained this statewide committee is "focused exclusively on resolving non-expedited behavioral health grievances for commercial Plan members." The Plan also reported a decline in the Department's Independent Medical Review (IMR) overturn rate since the committee's inception.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 13: Excerpts from CA Member Relations Behavioral Health Decision Making Committee: Annual Review: January 2024 to Current (October 18, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

The Plan's response failed to address all issues identified in this deficiency. While the Plan indicated a decline in the number of IMR overturns, the Plan provided no information on the current grievance categories and counts. For example, it is unknown whether grievances have continued to increase, whether enrollees have continued to grieve about similar issues, and whether the same medical centers continue to be in the "risk quadrant." Most importantly, it is unknown whether the Plan documented that the quality of care provided is being reviewed, problems are being identified, or took

effective action to improve care where deficiencies are identified as required by Rule 1300.70(a)(1).

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of grievance and appeal reports, policies and procedures, committee meeting minutes, files, interviews, and any other review deemed necessary by the Department.

Deficiency #10: The Plan's Quality Oversight Committee does not meet quarterly and is acting at variance with its committee charter.

Statutory and Regulatory References: Section 1351; Section 1386(b)(1); Rule 1300.51(d), Item J; Rule 1300.70(b)(2)(C).

Assessment: Rule 1300.70(b)(2)(C) requires the Plan's QA committee to meet on a quarterly basis, or more frequently if problems have been identified. Section 1386(b)(1) provides the Department with grounds to take disciplinary action should the Plan operate at variance with the basic organizational documents filed with the Department pursuant to Section 1351. These basic organization documents include the Plan's Quality Program Description, as required by Section 1351(m), Rule 1300.51(d), Item J1, and Rule 1300.70(b)(2)(A).[120]

The NCAL Quality Program Description establishes the Plan's processes to continuously review the quality of care, performance of medical personnel, and quality of services provided to enrollees.[121] The Quality Program Description requires the Plan to establish a QOC for NCAL.[122] The QOC has the "authority to speak and act on behalf of Kaiser Foundation Hospitals (KFH), [the Plan], and The Permanente Medical Group (TPMG) senior leadership on quality improvement issues."[123] The QOC "reports its activities and functions to the [Plan's and hospital's boards of directors (BOD)]."[124]

The Quality Program Description includes a charter outlining the QOC's responsibilities. The charter requires the QOC to "meet monthly, for no less than ten months of the year."[125] The Plan provided nine sets of QOC meeting minutes during the nonroutine survey review period:[126]

- September 11, 2019
- November 13, 2019
- May 13, 2020
- September 9, 2020

[120] eFiling #20230906.
[121] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 8.
[122] *Id*., page 10.
[123] *Id*., page 49.
[124] *Id*., page 50.
[125] *Id*.
[126] The nonroutine survey review period is May 1, 2019 through April 30, 2022.

- November 11, 2020
- March 10, 2021
- September 8, 2021
- November 3, 2021
- March 9, 2022

The QOC failed to meet quarterly in 2020 and 2021, as required by Rule 1300.70(b)(2)(C). Moreover, the QOC did not meet at least 10 months in 2019, 2020, or 2021, as required by its charter.

As the QOC did not meet "ten months of the year" as required by its charter, it is unknown whether the QOC received reports from the seven subcommittees and BHQOC. It is also unknown how the QOC oversaw the Plan's QA program, whether any issues were identified, if any corrective actions were taken, or if any identified issues were reported to the BOD. Given the importance of the QOC's integral role as part of the Plan's QA program, the committee's failure to meet regularly demonstrates inconsistent and inadequate oversight of the Plan's QA responsibilities.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> The finding is erroneous. The Plan submitted nine sets of QOC meeting minutes in response to the Department's requests during the survey. However, those meeting minutes were only a sampling of the meeting minutes kept by the QOC. The QOC did, in fact, meet monthly (at least 10 times per year) as required by its charter. Additional meeting minutes are submitted with this response.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 14: *Quality Oversight Committee Minutes* (2019 through 2022)

Final Report Deficiency Status: Corrected

Based on the documentation provided, the Department has determined this deficiency is corrected.

During the Nonroutine Survey, the Department requested the Plan submit for the review period: "Monthly [QOC] meeting minutes, including any and all materials provided to committee members in advance of and at the meetings."[127] The Plan failed to inform the Department it provided "only a sampling" of the requested records.

In response to this deficiency, the Plan submitted monthly QOC minutes from:

- January through December 2019
- January through March, May through December 2020

[127] Document Request #N1.

- January through December 2021
- January through December 2022

Based on review of the responsive documentation submitted with the Plan's response to the Preliminary Report, the Department determined the QOC met quarterly as required by Rule 1300.70(b)(2)(C), and at least 10 times a year, as mandated by the committee's charter.

Deficiency #11: The Plan's governing body and quality assurance committee do not adequately oversee their respective quality assurance program responsibilities.

Regulatory Reference: Rule 1300.70(b)(2)(C).

Assessment: Rule 1300.70(b)(2)(C) requires the Plan's governing body and its QA Committee to meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.[128]

The Plan's BOD meets quarterly and "has ultimate accountability and responsibility for the quality of care and service provided to members."[129] The BOD created the QHIC.[130] The QHIC, designed for the BOD to "meet its quality oversight responsibility,"[131] meets at least quarterly[132] and is tasked with duties such as providing "strategic direction for quality assurance and improvement systems," monitoring the provision of quality care and services on behalf of the BOD, and overseeing the Plan's QA and improvement systems.[133] During each BOD meeting, the QHIC reports on quality of care and services for enrollees and provides follow-up as appropriate or requested.[134]

The QOC is the Plan's quality oversight committee for NCAL.[135] There are 14 service areas in NCAL.[136] Each service area has a leadership team which:

> …ensur[es] that the Quality Program addresses the quality of care, utilization management, and services provided/available to all members within their respective service area. Each leadership team reports quality,

[128] Rule 1300.67.11(c) defines "governing body" as "the board of directors, all general partners, the sole proprietor, the board of trustees, and any other persons occupying a similar position or performing similar functions."
[129] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 9.
[130] *Id*., pages 9, 38.
[131] *Id*., page 9.
[132] *Id*., page 10.
[133] *Id*., page 38.
[134] *Id*., page 9.
[135] *Id*., pages 10, 49.
[136] *Id*., page 7.

> safety, utilization, and service activities and metrics to the QOC, which in turn reports this information to the [Plan BOD's] QHIC.[137]

The QOC assigns responsibilities to seven subcommittees[138] and the BHQOC.[139] The committees are required to report to the QOC periodically.[140,141] As required by its charter, the QOC meets monthly, "for no less than ten months of the year."[142] As identified in Deficiency #10, the QOC failed to meet on at least a quarterly basis in 2020 and 2021. The QOC also failed to meet at least 10 months each year in 2019, 2020, and 2021.

Due to the QOC's inconsistent and inadequate oversight of the seven subcommittees and BHQOC, the QOC is incapable of identifying quality issues affecting enrollees and presenting the QHIC with timely and comprehensive reports. Without these reports, the QHIC and the BOD are unable to sufficiently oversee the Plan's QA program and make improvements, as necessary.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan requested "the [F]inal [R]eport exclude this deficiency" because "its [QOC] meets monthly in accordance with both the statutory and regulatory requirements, and its charter."

The Plan stated:

> The QOC meeting minutes include periodic reports from its subcommittees, and from the BHQOC. In addition, the QOC reported to the QHIC on a quarterly basis throughout the survey period. With these reports, the QHIC and BOD were able to sufficiently oversee the Plan's QA program and make improvements, as necessary.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 14: *Quality Oversight Committee Minutes* (2019 through 2022)

Final Report Deficiency Status: Not Corrected

Based on the Plan's response and the meeting minutes provided, the Department has determined this deficiency is not corrected.

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[137] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 7.
[138] Access Committee, Member Concerns Committee, Regional Credentials and Privileges Committee, Regional Infection Control Committee, Regional and Sub-Regional Services Committee, Resource Management Committee, Risk Management/Patient Safety Committee.
[139] *Kaiser Foundation Health Plan, Inc. Northern California Region 2022 Quality Program Description*, page 14.
[140] The seven subcommittees are required to report to the QOC at least quarterly, or more often as necessary. *Id*., page 12. The BHQOC reports its activities to the QOC on a semiannual basis. *Id*., page 14.
[141] *Id*., pages 54, 56, 59, 64, 68, 71, 74.
[142] *Id*., page 50.

As determined in Deficiency #10, the QOC met quarterly as required by Rule 1300.70(b)(2)(C), and at least 10 times a year, as mandated by the committee's charter. Although the QOC meeting minutes contain references to the QHIC, the references primarily pertain to the QOC submitting various documents to the QHIC for review and approval. There are very few MH/SUD references in the QHIC entries.[143] It is unknown what, if any, information from the QOC the QHIC and BOD are reviewing and taking into consideration when overseeing and improving the Plan's QA program.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, meeting minutes, interviews, and any other review deemed necessary by the Department.

SOUTHERN CALIFORNIA

Deficiency #12: The Plan fails to ensure nonurgent appointments with nonphysician mental health care or substance use disorder providers are offered within 10 business days of the initial appointment request.

Statutory and Regulatory References: Section 1367.03(a)(5)(E), (H); Section 1367.03(e)(2); Rule 1300.67.2.2(c)(5)(E), (G).

Assessment: Section 1367.03(a)(5)(E), Rule 1300.67.2.2(c)(5)(E), and the Plan's *Oversight & Monitoring for Access and Availability* policy require the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees nonurgent appointments with a nonphysician mental health care or substance use disorder provider within 10 business days of the request for the appointment.[144] Section 1367.03(a)(5)(H) and Rule 1300.67.2.2(c)(5)(G) allow this 10 business day requirement to be extended if the provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Section 1367.03(e)(2) defines "appointment waiting time" as:

> ...the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the Plan or completing any other condition or requirement of the Plan or its contracting providers.

[143] In four years of QOC meeting minutes (2019 through 2022), only the August 12, 2020 and April 13, 2022 meeting minutes tangentially mention QHIC and MH/SUD issues on pages 250-251 and 544, respectively.
[144] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 3.

To receive a MH/SUD appointment, SCPMG permits enrollees to self-refer or request a referral through their primary care provider or other specialty provider.[145] Enrollees are then triaged to determine disposition:

> In SCAL, for an initial disposition, a patient undergoes a Kaiser Permanente Entry Pathway (KPEP) screening. To be clear, SCAL does not consider the KPEP screening to be an appointment.[146]

If urgent or emergent care is not needed, then enrollees are scheduled an intake appointment. During interviews, SCPMG stated the 10-business day requirement applies to intake, not triage, as the intake appointment marks the beginning of treatment.

The Department reviewed 71 SCPMG AR 1 files, 71 SCPMG AR 2 files, and 71 SCPMG AR 3 files.[147] Of these files, 44 SCPMG AR 1 files (62%),[148] 60 SCPMG AR 2 files (85%),[149] and 62 SCPMG AR 3 files (87%)[150] failed to demonstrate intake appointments were offered within 10 business days of the initial request for health care services by an enrollee or the enrollee's treating provider.

Case Examples

- **DMHC SCPMG AR 1 File 2:** The enrollee sought treatment for "thoughts of wanting to harm self" on May 11, 2021. The call was transferred to the on-duty clinician who performed a risk assessment and concluded the enrollee was appropriate for routine intake. The enrollee was scheduled for intake on May 27, 2021, 13 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10 business days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

- **DMHC SCPMG AR 2 File 48:** The enrollee had been under the care of a psychiatrist for generalized anxiety disorder and panic disorder. The enrollee's last appointment was on September 15, 2020. Due to increasing symptoms of anxiety, she reached out to request treatment on July 23, 2021.[151] The enrollee was scheduled for an intake appointment on November 15, 2021, 78 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10

[145] S23_SCAL Plan Response, page 1.
[146] S17_SCAL Plan Response, page 1.
[147] SCPMG AR 1 Files include appointments documented as canceled by the enrollee. SCPMG AR 2 Files include appointments documented as canceled by the provider. SCPMG AR 3 Files include appointments documented as "no show."
[148] DMHC SCPMG AR 1 Files 2, 5, 7, 8, 10, 12, 16, 18, 21-23, 26-28, 30-32, 34, 35, 37, 38, 40-44, 47, 49-61, 65, 68-70.
[149] DMHC SCPMG AR 2 Files 1, 3, 5, 6, 9-22, 24-32, 35-39, 42, 43, 45-70.
[150] DMHC SCPMG AR 3 Files 1, 3, 6-11, 13-22, 24-26, 28, 29, 31-38, 40-46, 48-71.
[151] This file was incomplete, as the enrollee had three appointments in 2020 with no medical records in the file. The July 23, 2021 email was the first record in the file, where the enrollee indicated she sent the provider "a few months ago asking for a therapist." DMHC SCPMG AR 2 File 48, page 120.

business days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

- **DMHC SCPMG AR 3 File 48:** The 12-year-old enrollee's mother sought treatment for enrollee's "anger due to parents getting a divorce" on November 19, 2021. The enrollee was scheduled for an intake appointment on December 29, 2021, 26 business days after the initial appointment request date. This file is deficient because there was no note in the relevant record an appointment was offered within 10 business days of the appointment request or that a longer waiting time would not have a detrimental impact on the enrollee's health.

TABLE 5
Nonurgent Appointments with Nonphysician MH/SUD Providers

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
SCPMG AR 1	71	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	27 (38%)	44 (62%)
SCPMG AR 2	71	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	11 (15%)	60 (85%)
SCPMG AR 3	71	Nonurgent appointment with a nonphysician MH/SUD provider offered within 10 business days of the appointment request	9 (13%)	62 (87%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated the "finding was included in and addressed in connection with the CAWP as part of Corrective Action Area Number 2: Access, and Corrective Action Area Number 3: Network & Referrals." In addition:

> …These issues were also identified in the Settlement Agreement, and the Plan has been engaged in ongoing efforts to correct the deficiency as described below and in the CAWP…

> As described in the Settlement Agreement, the Plan made commitments to "improve its procedures to ensure that its enrollees can access behavioral health appointments consistent with timely access standards." …The Plan has made good on that commitment by significantly expanding its provider network and by developing the CAWP…
>
> This deficiency and any corrective actions associated with it are incorporated into the Settlement Agreement. In particular, the finding is within the scope of Corrective Action Area No. 2: Access. With respect to that Corrective Action Area, the CAWP currently includes (but is not limited to) the following relevant actions:
>
> - Expand the external contracted network by more than 7,500 clinicians;
> - Increase internal medical group staffing;
> - Refine the supply and demand dashboard as needed based on the Behavioral Health team's analysis;
> - Ensure monthly monitoring of each medical center's compliance with timely access requirements;
> - Ensure monthly monitoring of documentation of non-detriment statements for initial access and SB 221 standards;
> - Ensure comparable analysis is performed across external contracted providers; and
> - Provide virtual treatment for mild to moderate depression or anxiety through the ADAPT program.
>
> This deficiency may also be deemed to be within the scope of Corrective Action Area No. 3: Network & Referrals. With respect to that Corrective Action Area, the CAWP currently includes actions aimed at expanding the provider network, as well as improving the process for making and monitoring referrals to external providers.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 1: Settlement Agreement (October 11, 2023)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of appointment data, reports and reporting tools, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #13: The Plan does not promptly reschedule appointments in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.

Statutory and Regulatory References: Section 1367.03(a)(3); Rule 1300.67.2.2(c)(3).

Assessment: If it is necessary for a provider or an enrollee to reschedule an appointment, Section 1367.03(a)(3), Rule 1300.67.2.2(c)(3), and the Plan's *Oversight & Monitoring for Access and Availability* policy require the Plan to promptly reschedule the appointment in a manner appropriate for the enrollee's health care needs and ensure continuity of care consistent with good professional practice.[152] Specifically, when an enrollee does not show up to an appointment, the Plan expects "providers will make three calls to patient over a 5-day period."[153]

The Department reviewed 71 SCPMG AR 1 files, 71 SCPMG AR 2 files, and 71 SCPMG AR 3 files. Of these files:

- SCPMG AR 1: 41 out of 71 files (58%)[154] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 41 files, 14 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[155]

- SCPMG AR 2: 36 out of 71 files (51%)[156] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 36 files, 10 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[157]

[152] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 3.
[153] KPEP Provider Hub FAQs, page 3.
[154] DMHC SCPMG AR 1 Files 4, 6-10, 12, 14, 15, 18, 20-22, 24-26, 28, 29, 31, 32, 36, 39, 40, 42, 43, 48-52, 54, 57, 58, 60, 61, 65-67, 69.
[155] DMHC SCPMG AR 1 Files 1, 4, 6, 9-11,18, 26, 32, 36, 42, 69-71.
[156] DMHC SCPMG AR 2 Files 1, 3, 4, 7 ,8, 10, 12, 13, 16-19, 22, 25, 28 ,29, 31-33, 38-41, 45, 46, 49, 50, 53, 59, 60, 62, 65, 67-69.
[157] DMHC SCPMG AR 2 Files 3,10, 25, 33, 38-40, 44, 49, 65.

- SCPMG AR 3: 57 out of 71 files (80%)[158] had no evidence of provider outreach to reschedule the canceled or missed appointments. In addition, of these 57 files, 26 files contained no evidence of further engagement with enrollees after the canceled or missed appointments.[159]

Case Examples

- **DMHC SCPMG AR 1 File 8:** The enrollee was receiving medication management services, individual therapy, and group therapy for anxiety disorder. Medical records showed an appointment scheduled for April 23, 2020 was canceled by the clinician. There was no documentation of why the appointment was canceled, or any attempts by the provider to reschedule the appointment. The next scheduled therapy appointment occurred on March 29, 2021, over 11 months later.

  This file is deficient because the canceled appointment was not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

- **DMHC SCPMG AR 2 File 10:** The enrollee was receiving individual therapy for recurrent Major Depressive Disorder with Psychotic Features. Medical records showed a therapy appointment scheduled for February 17, 2022 was canceled by the clinician. There was no documentation of why the appointment was canceled, or any attempts by the provider to reschedule the appointment. Records showed the enrollee was "wait listed," but there were no further documented encounters with the enrollee.

  This file is deficient because the canceled appointment was not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

- **DMHC SCPMG AR 3 File 5:** The enrollee was receiving medication management services for Major Depressive Disorder and Schizophrenia. Medical records showed the enrollee missed her January 26, 2022 appointment. There was no documented attempt by the provider to reschedule the appointment. In addition, there were no further documented encounters with the enrollee after the missed appointment.

  This file is deficient because the appointment was not promptly rescheduled in a manner appropriate for the enrollee's health care needs and failed to ensure continuity of care consistent with good professional practice.

[158] DMHC SCPMG AR 3 Files 1, 3, 5, 6, 10, 11,13-15, 17-29, 31-34, 37-44, 46-55 ,57, 59-62, 64-68, 70, 71.
[159] DMHC SCPMG AR 3 Files 6, 10, 15, 18-20, 23, 25, 27-29, 33, 34, 37, 39, 41, 42, 44, 51, 59, 61, 62, 64, 66, 68, 70.

TABLE 6
Rescheduled Appointments

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
SCPMG AR 1	71	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	30 (42%)	41 (58%)
SCPMG AR 2	71	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	35 (49%)	36 (51%)
SCPMG AR 3	71	Appointment is promptly rescheduled in a manner appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice	14 (20%)	57 (80%)

Plan's Compliance Effort: In response to the Preliminary Report, the Plan acknowledged the Department's findings "were also identified in the Settlement Agreement, and the Plan has been engaged in ongoing efforts to correct the deficiency."

The Plan asserted all corrective actions required to remediate this deficiency "are incorporated into the Settlement Agreement…within the scope of Corrective Action Area No. 2: Access." The Plan specifically noted the CAWP currently includes plans to:

- Strengthen and standardize policies and processes relating to initial follow-up and rescheduled behavioral health appointment access; and
- Expand monitoring of Medical Groups' return access availability.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 1: Settlement Agreement (October 11, 2023)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of appointment data, reports and reporting tools, policies and procedures, meeting minutes, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #14: The Plan's quality assurance program does not include the appropriate level of oversight to ensure clinicians are conducting suicide risk screenings, assessments, and treatment consistent with professionally recognized standards of practice.

Regulatory References: Rule 1300.70(a)(1), (a)(4)(D), (b)(1)(A), (b)(2)(A)-(C).

Assessment: Rule 1300.70(b)(1)(A) requires the Plan to ensure a level of care which meets professionally recognized standards of practice is being delivered to all enrollees.

Rule 1300.70(b)(2)(A) mandates the Plan to maintain a written QA plan describing its methodology for on-going monitoring and evaluation of health services. To the extent the Plan's QA responsibilities are delegated within the Plan or to a contracting provider, Rule 1300.70(b)(2)(B) requires the Plan's documents to provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Rule 1300.70(b)(2)(C) mandates delegated entities to maintain records of its QA activities and actions. Further, the Plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice.

Rule 1300.70(a)(1) requires the Plan's QA program to document the quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

Finally, Rule 1300.70(a)(4)(D) authorizes the Department to evaluate "the level of activity of the [Plan's QA] program and its effectiveness in identifying and correcting deficiencies in care."

Professionally recognized standards of practice require clinicians to conduct a suicide risk screening and/or assessment for all enrollees receiving MH/SUD services during triage, intake, and as indicated thereafter.[160,161] Furthermore, for enrollees who have a documented risk of suicide, a level of care that is appropriate to the enrollees' assessed risk must be delivered in a timely manner.

The Plan delegates the responsibility to identify, review, and evaluate "relevant quality, patient safety, and other performance improvement measures" to the Southern California Kaiser Permanente BHQOC.[162] According to the Plan's Quality Program Description, "Patient safety activities" include "risk assessment and suicide prevention."[163] The BHQOC reports to the Southern California Quality Committee (SCQC),[164] which in turn reports to the QHIC, a subcommittee of the Plan's governing body.[165]

The Department determined the Plan failed to demonstrate its QA program includes sufficient level of oversight to ensure enrollees receive suicide risk screening, assessment, and treatment consistent with professionally recognized standards of practice. SCPMG conducts monthly Risk Assessment Audits to "assess if a clinical assessment for risk has been completed for Psychiatry Routine Behavioral Medicine patients who are booked out of standard,[166] not by own choice."[167] The audits ensure "risk assessments and outreach attempts [are] performed by clinical staff on or within 14 days of adjusted book date."[168] During this manual audit, "auditors look at a sample of up to 26 adult cases per medical center, and track performance."[169]

The audit requirement for risk assessments to be performed within 14 days fails to take into account enrollees with more serious conditions and treatment needs might need to undergo a sooner suicide risk screening. When suicide risk screening is delayed and

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[160] Simon, Robert I. "Suicide Risk Assessment: What is the Standard of Care?" Journal American Academy Psychiatry Law, Volume 30, pages 340-344, 2002.
[161] The Joint Commission, "the nation's oldest and largest standards-setting and accrediting body in health care," introduced a national patient safety goal for suicide prevention. Link to Joint Commission FAQs. Behavioral health care organizations are required to screen all patients using a validated screening tool. The PHQ-9 is one of several specifically mentioned examples. Further, an evidence-based risk assessment is required following a positive screen for thoughts of suicide. The Columbia Suicide Severity Rating Scale is one of the examples listed as an evidence-based risk assessment tool. Link to The Joint Commission. National Patient Safety Goal for suicide prevention: NPSG 15.01.01, EP 2. R3 Report: Issue 18, May 2019, pages 2-3.
[162] *2022 Quality Program Description Southern California Region* (March 25, 2022), page 18.
[163] *Id*.
[164] *Id*.
[165] *Id*., page 204.
[166] "Out of Standard" is any appointment offered more than 14 days after the book date. *Behavioral Health Quality Oversight Committee* Meeting Minutes, April 3, 2019, page 4.
[167] *Id*.
[168] Southern California Behavioral Health Risk Assessment Audit Summary, page 1.
[169] Risk Assessment Audit Proposal: Pediatrics Expansion Report (December 11, 2020).

unidentified, the Plan is unable to ensure enrollees receive timely care meeting professionally recognized standards of practice. In addition, these audits are limited to a very small number of enrollees. The Plan provided no evidence it performs quality assurance activities to ensure clinicians conduct suicide risk screenings, assessments, and treatment consistent with professional recognized standards of practice. Taken together, the Department found the Plan failed to submit evidence the BHQOC identifies, reviews, and evaluates patient safety measures pertaining to risk assessment and suicide prevention for all enrollees as required by its own Quality Program Description.

The Department also determined the Plan failed to demonstrate it takes effective action to improve care where deficiencies are identified and performs follow-up where indicated. The BHQOC sets its compliance threshold for audits at 80 percent.[170] If a medical center falls below this threshold, the BHQOC issues a Quality Alert[171] or corrective action plan (CAP)[172] "to medical centers failing to score above the performance threshold in both the rolling 3-month period, as well as the latest month."[173] The Department determined this process to be inconsistent with the requirement to continuously review the quality of care provided and take effective corrective action to resolve identified issues pursuant to Rule 1300.70(b)(1)(B), as medical centers that consistently fall below threshold in rolling three-month periods are not required to address identified issues as long as the current month is above threshold. For example, during the review period,[174] Kern County's Risk Assessment Audit scores fell below the Plan's compliance threshold in 22 out of 33 months:

- **2019:** May 57%, June 29%, July 63%, September 75%, November 70%, December 67%
- **2020:** January 50%, April 50%, June 50%, July 56%, August 63%, September 30%, December 0%
- **2021:** January 67%, February 27%, March 69%, June 73%, July 62%, September 69%, October 54%, November 77%
- **2022:** January 58%[175]

Although Kern County consistently fell below the Plan's compliance threshold throughout the survey review period, the BHQOC meeting minutes only contain evidence that two Quality Alerts and four CAPs were issued.[176] Further, the Plan

[170] *Behavioral Health Quality Oversight Committee* Meeting Minutes, April 3, 2019, page 5.
[171] A "Quality Alert" consists of three prompts a noncompliant medical center must address: (1) Root Cause Analysis, (2) Interventions Taken, (3) Accountable Leaders & Expected Date of Compliance. Southern California Behavioral Health Risk Assessment Audit Summary, page 2. In 2019, Quality Alerts were issued if a medical center was below threshold in a rolling three-month period.
[172] In April 2020, BHQOC started issuing CAPs instead of Quality Alerts. CAPs are comprised of the same three Quality Alert prompts. Southern California Health Risk Assessment Audit Corrective Action Plan.
[173] Risk Assessment Audit: October, November 2020 Report (December 11, 2020).
[174] The nonroutine survey review period is May 1, 2019 through April 30, 2022.
[175] The BHQOC meeting minutes contained no data for February through April 2022.
[176] The Quality Alerts were issued on July 19, 2019 and October 9, 2019. The CAPs were issued on April 24, 2020, September 2020, March 26, 2021, and December 28, 2021.

provided no documentation demonstrating the BHQOC followed up on these actions to evaluate their effectiveness in resolving the identified quality of care issues.

In addition, the Plan did not provide documentation demonstrating the BHQOC consistently issued Quality Alerts or CAPs to medical centers that were below the threshold. For example:

- On February 5, 2020, the BHQOC reviewed Risk Assessment Audits from August through October 2019 and found Orange County below the threshold in the rolling three-month audit period. The BHQOC also reviewed audits from September through November 2019 and again found Orange County below the threshold in the rolling three-month audit period. Finally, the BHQOC reviewed audits from October through December 2019 and found Kern County below the threshold in the rolling three-month audit period.

  Although Orange County was below the threshold from August through November 2019, no Quality Alert was issued. During these three audit periods, the BHQOC meeting minutes indicate a Quality Alert was issued only to Kern County;[177] however, the minutes contained no evidence this occurred.

- On December 16, 2021, the BHQOC reviewed Risk Assessment Audits from July through September 2021 and found Baldwin Park and Kern County below the threshold in the rolling three-month audit period and September 2021. No CAP was issued for either medical center.

Finally, the Department determined the Plan failed to provide evidence it maintains an oversight mechanism to ensure delegated QA functions are adequately performed. The Plan provided no evidence Risk Assessment Audit findings were reported to and reviewed by the SCQC or the QHIC as required by the Quality Program Description.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> The Plan notes that the Department's findings are inconsistent with available minutes and reports, including BHQOC minutes.
>
> The Plan notes that the Department's purported findings relate to documents and information from nearly five years ago and precede the Plan's 2023 Behavioral Health Settlement Agreement. The [CAWP] the Plan has implemented pursuant to that Settlement Agreement will encompass suicide risk assessments. The changes covered by the Work Plans include, among other things, expansion of the scope and functions of the BHQOCs including increasing the depth and frequency of their monitoring of performance on quality metrics and compliance with regulatory requirements and clinical quality treatment plan audits. Specific changes and oversight enhancements include, but are not limited to, the following:

[177] *Behavioral Health Quality Oversight Committee* Meeting Minutes, February 5, 2020, page 8.

- The oversight structure was revised to allow for specialized attention on behavioral health quality and the BHQ team was created in early 2022 and fully staffed by August 2022;
- Suicide risk and critical alert information is gathered and documented at every visit via the Treatment Progress Indicator (TPI). The monthly % success with obtaining completed TPIs was reported through BHQOC and was included in the BH Quality Dashboard until April 2024 and is now reported by the medical group during the suicide prevention report twice per year;
- Feedback informed care includes a self-assessment at most therapy sessions and risk screenings are a part of this self-assessment tool. The risk screenings result in critical alerts that notify clinical staff of when more frequent and immediate safety screenings and planning are clinically indicated; and
- The Risk Assessment audit, which looks for evidence of suicide/safety assessment for patients booked beyond standard, continues on a monthly basis and is reported in BHQOC monthly. Corrective Action Plans have been implemented when the standard is not satisfied.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (February 21, 2025)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan submitted no evidence to demonstrate the "changes and oversight enhancements" were implemented. In addition, the Plan did not provide any committee meeting minutes and reports or explanation to demonstrate how "the Department's findings are inconsistent with available meetings and reports."

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of chart audits, corrective action plans, reports, policies and procedures, meeting minutes, files, interviews, and any other review deemed necessary by the Department.

Deficiency #15: The Plan does not maintain an adequate system to document external provider referrals and monitor the follow-up of enrollees' health care documentation to ensure services are furnished in a timely and appropriate manner.

Statutory and Regulatory References: Section 1367(d); Rule 1300.67.1(d)-(e).

Assessment: Rule 1300.67.1(e) requires the Plan to provide an adequate system of documentation of referrals to physicians or other health professionals and monitor the follow-up of enrollees' health care documentation. Section 1367(d) mandates the Plan to furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice. Rule 1300.67.1(d) requires the Plan to ensure continuity of care by maintaining sufficient health professionals, administrative, and other supporting staff to assure that health care services will be provided on a timely and appropriate basis to enrollees.

The Department reviewed 71 SCPMG AR 1 files, 71 SCPMG AR 2 files, and 71 SCPMG AR 3 files. Of these files, 19 SCPMG AR 1 files,[178] 19 SCPMG AR 2 files,[179] and 22 SCPMG AR 3 files[180] contained evidence SCPMG referred enrollees to external providers. However, none of these files included medical records from these providers. There was no evidence SCPMG or the Plan made any efforts to confirm enrollees were able to access external provider services in a timely and appropriate manner. Several files included evidence enrollees made repeated attempts to schedule appointments with external providers without success. Further, file review revealed instances in which enrollees were likely lost to follow-up without documented provision of care received.

Case Examples

- **DMHC SCPMG AR 1 File 60:** On January 24, 2020, the enrollee completed an "Initial Mental Health screening" and was referred to an external provider.

  On February 2, 2021, the enrollee attended an appointment with a SCPMG psychiatrist. The SCPMG psychiatrist documented the enrollee was "doing therapy for about a year" and saw her therapist every two weeks.

  The enrollee's medical records reflect submission of "External Scans" for "external TPI Clinical Reports" on a monthly basis from February 17, 2020 through September 14, 2021. However, since the Department was unable to locate any documentation attached to these scans, it is unknown whether the external provider services furnished were timely and appropriate.

  This file is deficient because the Plan and TPMG failed to maintain an adequate system to document the enrollee's external provider referral and monitor the

[178] DMHC SCPMG AR 1 Files 6, 10, 12, 15, 18, 21, 35, 42, 44, 53-56, 58-60, 63, 64, 71.
[179] DMHC SCPMG AR 2 Files 4, 5, 9, 11, 15, 18, 19, 21, 25, 30, 34, 36-38, 42, 43, 46, 50, 70.
[180] DMHC SCPMG AR 3 Files 1, 7, 12, 13, 16, 17, 21, 22, 31, 34, 37, 38, 41, 46, 49, 50, 57, 63, 66, 69-71.

follow-up of the enrollee's documentation to ensure services are furnished in a timely and appropriate manner.

- **DMHC SCPMG AR 2 File 18:** On September 19, 2022, the enrollee was referred to an external psychiatrist for medication management services. The enrollee was previously seen by a SCPMG psychiatrist who left the medical group in January 2021. The enrollee went without a psychiatrist for several months until SCPMG eventually initiated a referral to an external provider when the enrollee requested a medication refill.

  On October 18, 2022 the enrollee contacted SCPMG to request another medication refill. During the call, the enrollee reported she was unable to access services from the external provider. The enrollee stated her initial appointment with the external provider was canceled and not yet rescheduled. A SCPMG physician refilled the prescription, but there was no evidence in the file demonstrating the enrollee received services from the external provider subject to SCPMG's referral.

  This file is deficient because the Plan and TPMG failed to maintain an adequate system to document the enrollee's external provider referral and monitor the follow-up of the enrollee's documentation to ensure services are furnished in a timely and appropriate manner.

- **DMHC SCPMG AR 3 File 37:** On September 17, 2020, the enrollee completed a triage appointment and was referred to an external provider for intake and individual therapy. The enrollee was "initially authorized for 24 sessions (1 initial visit and 23 returns)." The Department found no evidence in the file demonstrating the enrollee received services from the external provider.

  This file is deficient because the Plan and TPMG failed to maintain an adequate system to document the enrollee's external provider referral and monitor the follow-up of the enrollee's documentation to ensure services are furnished in a timely and appropriate manner.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> Some of the Department's summaries of the records are inaccurate and/or incomplete; the records do contain evidence that SCPMG endeavored to monitor and document care by external providers after referrals. Nonetheless, the Plan acknowledges the opportunity for improvement and the Settlement Agreement and CAWP address this issue.

The Plan asserted all corrective actions required to remediate this deficiency are "incorporated into the CAWP in connection with Corrective Action Area No. 3: Network & Referrals." The Plan indicated it had "begun the process for improving its system for documenting external provider referrals and monitoring the follow-up of enrollees' health care documentation."

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 1: Settlement Agreement (October 11, 2023)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken and proposed, the Department determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards resolving this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

The Plan failed to submit evidence to support its assertion that "[s]ome of the Department's summaries of the records are inaccurate and/or incomplete" and "the records do contain evidence that SCPMG endeavored to monitor and document care by external providers after referrals."

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #16: The Plan does not maintain medical records in a manner which provides continuity of care.

Regulatory Reference: Rule 1300.67.1(c).

Assessment: Rule 1300.67.1 requires the Plan to provide services "in a manner which provides continuity of care." As part of this requirement, Rule 1300.67.1(c) mandates the Plan to ensure medical records are maintained and readily available "with sharing within the plan of all pertinent information relating to the health care of each enrollee."

The Department reviewed 71 SCPMG AR 1 files, 71 SCPMG AR 2 files, and 71 SCPMG AR 3 files. Of these files, the Department determined 70 SCPMG AR 1 files (99%),[181] 71 SCPMG AR 2 files (100%),[182] and 71 SCPMG AR 3 files (100%)[183] included insufficient documentation to demonstrate medical records are maintained and readily available in a manner which provides continuity of care. Medical records were frequently incomplete or missing pertinent documentation of the initial treatment

[181] DMHC SCPMG AR 1 Files 1-27, 29-71.
[182] DMHC SCPMG AR 2 Files 1-71.
[183] DMHC SCPMG AR 3 Files 1-71.

request,[184] triage,[185] and intake.[186] In addition, there were discrepancies between appointment records and clinical treatment notes.[187]

The Department also identified 21 SCPMG AR 1 files,[188] 18 SCPMG AR 2 files,[189] and 27 SCPMG AR 3 files[190] included documentation indicating enrollees were referred to external providers. None of these files contained medical records documenting pertinent information about what care, if any, the enrollees received from the external contracting providers.

Case Examples

- **DMHC SCPMG AR 1 File 42:** The enrollee's medical records failed to include documentation of the initial request for treatment, triage, and initial intake assessment.

  Appointment records documented a "Referral Psychiatry External" occurred on July 7, 2020. However, there was no corresponding documentation in the enrollee's medical records of the referral or communication to the enrollee about the referral.

  Appointment records also documented a Marriage and Family Therapist (MFT) held a "Positive Motherhood Transitions Group Referral" follow-up appointment with the enrollee on July 22, 2020. The MFT's note states: "Social Medicine Assessment completed: 7-21-20." There was no corresponding chart documentation of the assessment. Additionally, the appointment records failed to contain any documentation corresponding with the follow-up appointment.

  Similarly, a MFT documented a "Referral to KP Contracted External Provider" for weekly therapy was made on August 28, 2020. However, there was no corresponding chart documentation in the enrollee's medical records indicating

[184] DMHC SCPMG AR 1 Files 5, 7, 8, 10-12, 15, 16, 18, 21-23, 25, 27, 29-37, 40-42, 47, 50, 51, 53-57, 59-63, 65, 68, 69, 71. DMHC SCPMG AR 2 Files 3, 5, 6, 9-22, 24-32, 35-39, 42, 43, 45-47, 49-70. DMHC SCPMG AR 3 Files 1-3, 5-10, 13-22, 24, 25, 28, 29, 31-38, 40-46, 48, 49, 51-71.
[185] DMHC SCPMG AR 1 Files 1, 5, 7-12, 14-16, 18, 21-23, 25, 27, 29-32, 34, 35, 37, 40-42, 44, 47, 48, 50-57, 59-63, 65, 67-69, 71. DMHC SCPMG AR 2 Files 1, 3-6, 9-25, 27-32, 34-39, 43, 45-47, 49, 50, 52-70. DMHC SCPMG AR 3 Files 5-7, 11, 12, 14, 15, 17-22, 24-27, 29-33, 35, 37, 38, 40-43, 45, 46, 48-51, 53-62, 64-66, 68, 69, 71.
[186] DMHC SCPMG AR 1 Files 5, 8, 12, 16, 18, 22, 23, 26-28, 30-32, 34, 35, 37, 40-42, 47, 51, 53, 56, 57, 60, 61, 64, 68. DMHC SCPMG AR 2 Files 1, 3, 5, 6, 9, 10, 12-15, 17-21, 24, 25, 27-32, 35-39, 42, 43, 45-47, 49, 52-54, 57, 58, 60, 63-66, 69, 70. DMHC SCPMG AR 3 Files 1, 2, 14, 17-22, 24, 37, 40, 41, 43, 45, 46, 49, 54, 58, 60, 61, 65, 68, 69, 71.
[187] DMHC SCPMG AR 1 Files 1, 4, 6, 9-11, 18. 26, 32, 36, 42, 69, 70, 71. DMHC SCPMG AR 2 Files 2, 6, 9, 12, 14, 18-23, 27-29, 31, 32, 35-38, 41, 43, 45-48, 53, 54, 56-58, 60, 63-66, 69. DMHC SCPMG AR 3 Files 2, 5, 9, 20, 24, 38, 44, 50, 53, 57, 58.
[188] DMHC SCPMG AR 1 Files 6, 10, 15, 18, 19, 21, 32, 35, 42, 44, 53-56, 58-61, 63, 64, 71.
[189] DMHC SCPMG AR 2 Files 4, 5, 9, 11, 15, 18, 19, 21, 25, 30, 34, 36-38, 43, 46, 50, 70.
[190] DMHC SCPMG AR 3 Files 1, 2, 7, 12-14, 16, 17, 20-22, 31, 32, 34, 37, 38, 41, 46, 49, 50, 57, 58, 63, 66, 69-71.

whether the enrollee received services from an external provider as a result of the referral.

This file is deficient because the Plan and SCPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care.

- **DMHC SCPMG AR 2 File 12:** The enrollee's medical records failed to include documentation of the initial request for treatment, triage, and initial intake assessment.

  Appointment records indicate SCPMG providers scheduled eight appointments with the enrollee between September 2, 2021 through May 4, 2022. However, there was no corresponding chart documentation for any of these appointments within the enrollee's medical records.

  This file is deficient because the Plan and SCPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care.

- **DMHC SCPMG AR 3 File 53:** The enrollee's medical records failed to include documentation of the initial request for treatment and triage.

  The enrollee's medical records document nine appointments took place between August 3, 2021 through November 15, 2021. However, there was no corresponding documentation for any of these appointments within the appointment records.

  This file is deficient because the Plan and SCPMG failed to maintain the enrollee's medical records with all pertinent information in a manner which provides continuity of care.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated:

> The Plan does not agree with the finding. The Medical Groups maintain patients' medical records using state-of-the-art software and technology. That software and technology is designed to enable ready sharing of an enrollee's records within the Plan. However, sharing of information outside the Plan is not as simple. The Plan *compiled* information from the medical records in an effort to fully respond to the Department's requests. However, the Plan did not produce the *entire* medical records of its enrollees. As such, the files that the Plan produced in response to the Department's requests did not include all of the information that exists in the medical records. To the extent the Department has identified gaps in the medical records, or discrepancies between appointment records and clinical treatment notes, that is not because the record is incomplete, but rather because the files in the Department's possession represent only a portion of the complete record.

The Plan indicated it reviewed the Department's case examples and was able to locate some of the missing documentation with the enrollee's complete medical records, stating:

> [I]n SCPMG AR 1 File 42[,]…the Department determined that the record lacked documentation corresponding to the "Referral Psychiatry External" noted on July 7, 2020. However, in the complete record, the referrals tab includes a "Notice of Authorization of Services" letter that was mailed to both the member and the provider… That letter includes detailed information about the provider the member was referred to, the dates the authorization was valid, the member's copay, and the number of authorized visits (1 intake and 23 returns). The letter also includes additional information asking the member to bring the letter to her first visit, and provides a phone number she can call if she has any questions.
>
> Similarly, the Department found no chart documentation corresponding to the "Social Medicine Assessment" noted as having been completed on July 21, 2020. However, records associated with the Social Medicine Department were not included in the material that was produced. Those records include a full assessment completed in the chart by the Social Medicine Social Worker, dated July 21, 2020.
>
> The Social Medicine Department's record also includes a detailed telephone outreach dated July 22, 2020, which relates to the member's referral to the Positive Motherhood Transitions Group. The record indicates the patient returned the call the same day and scheduled a screening for a postpartum group assessment with a therapist for July 23, 2020, which the patient attended.
>
> Finally, the Department found no chart documentation corresponding to an MFT documented "Referral to KP Contracted External Provider" on August 28, 2020. The full record documents two outreach attempts to contact the member about the referral (which was recommended by the member's group therapist). However, the member did not answer the calls, or otherwise respond to the outreach. As such, the referral was not placed.

The Plan stated:

> In short, there is no defect in the Plan's record-keeping processes. It was simply not feasible to produce every enrollee's entire medical record in connection with the Survey. Unfortunately, some variation in compliance among individual providers is simply inevitable. However, the Plan has systems in place designed to maximize compliance with standards—including training, monitoring, and quality audits.

Finally, the Plan asserted it "does not agree that corrective action is necessary" and it "has not engaged in efforts to modify its record-keeping processes." The Plan indicated "any actions needed to improve record keeping processes…may

be addressed in Corrective Action Area 2: Access…[and] as part of Corrective Action Area 8: Continuous Detail & Comprehensive Review."

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)
- Exhibit 16: Additional Record SCPMG AR 1 File 42 (October 18, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions proposed, the Department has determined this deficiency is not corrected.

During the Nonroutine Survey, the Department requested the Plan submit the following records for each case file selected for review:

Behavioral Health/Mental Health/Substance Use Disorder (BH/MH/SUD) Appointments

For each case file, provide the requested information listed below as a single PDF. To assist efficiency of review, please bookmark the PDF document. Please title the bookmarks as follows:

1. File ID #
2. The appointment selected by the Department
3. Each individual BH/MH/SUD appointment
4. Any communications between staff and providers (internal and external), including but not limited to, communications in Microsoft Teams
5. Amendments to medical records and notes after initial submission

File contents must include all medical records, plan and provider notes or comments, internal and external communications, screen prints and all other documentation showing the enrollee's case of care including the initial request for BH/MH/SUD services, triage, and any subsequent requests for BH/MH/SUD services. The file should contain all BH/MH/SUD appointments for the selected enrollee in chronological order.

All files must include the following:

- File ID # (Plan's unique case identification number)
- Line of business (Individual, Small Group, Large Group or Medi-Cal)
- Name of enrollee, if applicable
- Enrollee ID #, if applicable
- Name of enrollee's assigned service area/medical center or other delegated entity, if applicable
- Enrollee's initial contact requesting MH/BH/SUD services. If the enrollee is referred by a provider, include the referral
- Enrollee's triage appointment

- Enrollee's intake appointment
- Any subsequent MH/BH/SUD appointments
- Any subsequent contact from the enrollee or their provider requesting MH/BH/SUD services
- Legend for each code or value contained in screen prints or other documentation provided

The Plan failed to inform the Department it only "produced excerpts from medical records" in response to the Department's above request. The Plan also failed to inform the Department it did not produce records documenting the enrollee's initial request for MH/SUD services if it occurred outside the survey review period.

The Plan did not produce evidence to support its assertion that, "[t]o the extent the Department has identified gaps in the medical records, or discrepancies between appointment records and clinical treatment notes, that is not because the record is incomplete, but rather because the files in the Department's possession represent only a portion of the complete record." Further, the Department determined the limited documentation submitted by the Plan in response to the Department's case examples did not alter its initial findings:

- **SCPMG AR 1 File 42:** The Department acknowledges the Plan submitted documentation of its external psychiatry referral on July 7, 2020, including a copy of its notice to the enrollee regarding the referral, chart documentation of the "Social Medicine Assessment" completed by an MFT on July 21, 2020, and documentation of attempts to contact the enrollee about the "Referral to KP Contracted External Provider" for weekly therapy was made on August 28, 2020. The Plan admitted it did not produce these records during the Department's Nonroutine Survey as originally requested. The Plan failed to submit any documentation showing it maintained records of the enrollee's initial request for services, triage, and initial intake assessment. Without such evidence, the Department finds the file remains deficient.

Further, it is also unclear to the Department if the remedial measures outlined in Corrective Action Area No. 2: Access of the Plan's CAWP are likely to correct this deficiency. The Department acknowledges Area No. 2 includes a commitment to develop improved policy and process to ensure providers:

> [F]ully document in the enrollees' medical records the date and time the enrollee requested behavioral health appointments, the date and time of the first available appointment that was offered to the enrollee, the date and time of the appointment the enrollee accepted, and if a statement of non-detriment or patient preference is documented in the enrollee's medical record.

However, the CAWP does not address what, if any, efforts the Plan will undertake to ensure medical records are maintained and readily available with sharing within the Plan of all pertinent information relating to the health care of each enrollee, as required

by Rule 1300.67.1(c). This includes documentation of intake, triage, and clinical treatment notes, which are not addressed in the Plan's CAWP.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of policies and procedures, training documents, files, interviews, and any other review deemed necessary by the Department.

Deficiency #17: The Plan is unable to ensure enrollees are offered urgent care appointments within 48 hours of the request for the appointment.

Statutory and Regulatory References: Section 1367.03(a)(5)(A)-(B); Rule 1300.67.2.2(c)(5)(A)-(B).

Assessment: Section 1367.03(a)(5)(A) and Rule 1300.67.2.2(c)(5)(A) require the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees urgent care appointments that do not need prior authorization within 48 hours of the request for the appointment. Section 1367.03(a)(5)(B) and Rule 1300.67.2.2(c)(5)(B) require the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees urgent care appointments that require prior authorization within 96 hours of the request for the appointment.

SCPMG requires all urgent appointments to be offered within 48 hours of the request regardless of whether prior authorization is needed.[191]

SCPMG generates two Trended Access Reports to monitor the compliance of timely access for behavioral health appointments booked in 13 regions[192] and seven counties.[193] In both the regional and county reports, the documented standard for urgent behavioral health appointments with physicians and non-physicians is two business days, which is inconsistent with the 48 hour requirement set forth in Section 1367.03(a)(5)(A), Rule 1300.67.2.2(c)(5)(A), and SCPMG's own access monitoring policy. Since the wrong timely access standard is used, SCPMG and the Plan are unable to ensure urgent appointments are provided or arranged in a timely manner.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated, "SCPMG has since updated the documented standard, effective November 2023. Since that time, *Trended Access Reports* have documented the 48- hour standard."

[191] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 3.
[192] The 13 regions are Antelope Valley, Baldwin Park, Downey, Kern County, Los Angeles, Orange County, Panorama City, Riverside, San Bernadino County, San Diego, South Bay, West Los Angeles, and Woodland Hills.
[193] The seven counties are Kern, Los Angeles, Orange, Riverside, San Bernadino, San Diego, and Ventura.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 17: *Trended Access Report Behavioral Health* (January 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

The Department finds the Plan has taken steps to correct this deficiency by updating the urgent appointment standard in the Trended Access Reports from two business days to 48 hours and providing the Department with the January 2024 report to reflect this update. However, the submission of one report does not demonstrate sustained compliance, and the Department must verify the Plan's corrective actions have effectively corrected this deficiency.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, interviews, and any other review deemed necessary by the Department.

Deficiency #18: The Plan fails to monitor and take effective action to correct identified access issues.

Statutory and Regulatory References: Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1); Rule 1300.70(a)(1), (3), (b)(1)(B).

Assessment: Section 1367.03(a)(1) and Rule 1300.67.2.2(c)(1) require the Plan to establish and maintain QA monitoring systems and processes sufficient to ensure services are provided in a manner consistent with good professional practice and in compliance with applicable timely access standards. Rule 1300.70(a)(3) similarly mandates the Plan's QA program to address accessibility and availability of care. Rule 1300.70(a)(1) and (b)(1)(B) require the Plan to take effective action to correct problems identified by its QA program.

The Plan's *Oversight & Monitoring for Access and Availability* policy describes its timely access monitoring process.[194] The policy states the Plan provides "oversight and monitoring of: ...Reviewing corrective action plans when oversight, monitoring, and/or auditing activities discloses that the Health Plan's Provider Network is insufficient to ensure timely access and availability."[195]

The policy also outlines an escalation process "when access to appointments or provider network availability is insufficient to meet member needs."[196] If access and availability standards are below established benchmarks in Southern California, the

[194] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 1.
[195] *Id*., page 3.
[196] *Id*., page 4.

policy requires SCPMG to submit an action plan to the Southern California Regional Access Committee (Access Committee).[197] If the action plan fails to remediate the identified access issue, then the Access Committee must "request additional actions for implementation by a service or medical center area."[198]

The *Trended Access* reports assess the timeliness of all new requests for MH/SUD appointments booked each month. The reports measure compliance for each medical center and each county in the Plan's SCAL region against its standard.[199] All medical centers and counties are required to achieve at least 80 percent compliance with applicable timely access standards. The reports are generated and reviewed by the Access Committee on a monthly basis.

In 29 of the 36 *Trended Access* reports generated throughout the review period, at least one service area or county fell below the required 80 percent compliance threshold.[200] Despite this finding, the Access Committee only initiated corrective actions to remediate the identified access compliance issues in 13 of these instances.[201]

The Access Committee meeting minutes consistently included the following statement: "The Regional Access Committee requires a report out when a [medical center] department is below the 80% booked within standard threshold for two consecutive months." The Department determined this established action is inconsistent with the requirement to continuously review the quality of care provided and take effective corrective action to resolve identified access issues, as set forth in Rule 1300.70(b)(1)(B). This practice also conflicts with the *Oversight & Monitoring for Access and Availability* policy, which requires an action plan be submitted to the Access Committee if access and availability fall below established benchmarks.[202]

Furthermore, the *Trended Access* reports do not include new appointment data for external providers. SCPMG and the Plan did not provide evidence to demonstrate an adequate QA monitoring system and process was established and maintained to ensure new MH/SUD appointments with external providers are provided in a manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

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[197] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 4.
[198] *Id*.
[199] SCPMG's timeliness standards are: Addiction medicine (physician): urgent two business days; non-urgent 15 business days. Addiction medicine (non-physician): urgent two business days; non-urgent 10 business days. Psychiatry (physician): urgent two business days; non-urgent 15 business days. Psychiatry (non-physician): urgent two business days; non-urgent 10 business days.
[200] All service areas and counties were above the 80 percent compliance threshold in the following monthly *Trended Access* reports: February 2020, April 2020, May 2020, June 2020, August 2020, April 2021, and August 2021. With the exception of these seven months, every other *Trended Access* report generated during the survey review period identified at least one service area or county below this benchmark.
[201] The following Access Committee meeting minutes indicate corrective action was required in response to the *Trended Access* report: June 2019, July 2019, August 2019, December 2019, January 2020, February 2020, December 2020, July 2021, August 2021, November 2021, December 2021, January 2022, and March 2022.
[202] *Oversight & Monitoring for Access and Availability* (Southern California Region), page 4.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated it:

> …respectfully disagrees with the Department's legal and factual findings. First, Rule 1300.70(b)(1)(B) requires that the Plan's quality assurance program be designed to ensure that quality of care problems are identified and corrected. It does not dictate particular means or specific timetables for identifying and correcting quality of care problems. The Plan's established 2-consecutive-month standard for triggering a formal corrective action plan satisfies that requirement. As the *Trended Access Reports* demonstrate, each service area must track and report its compliance with the access standard on a monthly basis. The Access Committee's "established action" gives leaders in the service area both an opportunity and the incentive to make voluntary course corrections to improve performance quickly and avoid formal corrective action.
>
> Notably, the fact that a service area or county falls below the compliance threshold in a single month does not necessarily indicate a need for major changes. Indeed, a one-month snapshot may inaccurately suggest the need for corrective action where no need exists. For example, where an unanticipated illness or provider absence created a short-term gap. As explained above, better performance may be achieved with simple course corrections under the direction of local leadership. On the other hand, a shortfall in two consecutive months does indicate that more formal intervention is warranted. In those instances, the requirement for formal corrective action plans ensures that necessary steps are taken to correct the identified problem. As such, the 2-consecutive-month standard is designed to promote the identification and correction of access issues as quickly as possible.
>
> There is no conflict between the Access Committee's 2-consecutive-month standard and the Plan's *Oversight & Monitoring for Access and Availability Policy.* While the policy requires Service Area Managers and Physicians-in-Chief to submit action plans if access and availability fall below established benchmarks, it does not dictate any specific criteria for *when* the Access Committee must deem a service area to have fallen below the benchmark for purposes of requiring a formal action plan.
>
> Finally, at the time of the Survey, the 2-consecutive-month standard had been established for several years. While the Plan has been unable to identify specific documentation wherein the Department expressly approved that standard, the Plan is informed and believes the Department was previously aware of it, and had never suggested it was insufficient to comply with regulatory requirements. The Plan requests that the [F]inal [R]eport exclude any survey information, legal findings, or conclusions that the Plan violated the statutory or regulatory requirements due to the Access Committee's established action of requiring a corrective action plan where a service area or county falls below the compliance threshold for [two] or more consecutive months.

> As noted in the Preliminary Report, *Trended Access Reports* do not include new appointment data for external providers. The Plan accepts this finding. Actions to improve monitoring of external providers are under consideration in connection with the CAWP.

The Plan indicated it "has begun the process for improving its system for monitoring and remediating timeliness of access issues with respect to external providers, as described in the most recent iteration of the CAWP (See Corrective Action Area Number 2: Access)."

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 2: Corrective Action Work Plan (August 15, 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

While the Department acknowledges the Plan took steps towards correcting this deficiency, the Plan's remedial efforts are ongoing and additional time is necessary for the Plan to complete implementation of its corrective actions.

The Plan's disagreement with the Department's legal and factual findings is unfounded, as the Department's analysis is based on inconsistencies between the requirements set forth in the *Oversight & Monitoring for Access and Availability* policy and the Access Committee's actions. Specifically, the policy requires SCPMG to submit an action plan to the Access Committee "when access to appointments or provider network availability is insufficient to meet member needs." The escalation process outlined in the policy is triggered "when access to appointments or provider network availability is insufficient to meet member needs," not when a service area falls below threshold for two or more consecutive months.

Although the Plan indicated "there is no conflict between the Access Committee's 2-consecutive-month standard and the Plan's *Oversight & Monitoring for Access and Availability Policy*," the Plan has not demonstrated the Access Committee's standard is a reasonable process. For example, if a service area falls below standard every other month, then no action is necessary even though the service area is below standard six months out of the year. Thus, based on current practices, the Plan does not "continuously review the quality of care provided…and does not ensure that quality of care problems are identified and corrected for all provider entities," as required by Rule 1300.70(b)(1)(B).

Furthermore, while the Plan acknowledged its inadequate monitoring of the timeliness of new external provider appointments, it provided no explanation why the Access Committee did not initiate corrective actions to remediate identified access compliance issues in all service areas.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, policies and procedures, meeting minutes, interviews, and any other review deemed necessary by the Department.

Deficiency #19: The Plan's governing body and quality assurance committee do not adequately oversee their respective quality assurance program responsibilities.

Regulatory Reference: Rule 1300.70(b)(2)(C).

Assessment: Rule 1300.70(b)(2)(C) requires the Plan's governing body and its QA Committee to meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.

The Plan's BOD meets quarterly and "has ultimate accountability and responsibility for the accessibility, quality of care, and service provided to members."[203] The BOD established the QHIC as a subcommittee for the BOD to "meet its quality oversight responsibility."[204,205] The QHIC meets at least quarterly[206] and is tasked with duties such as providing "strategic direction for quality assurance and improvement systems," monitoring the provision of quality care and services on behalf of the BOD, and overseeing the Plan's QA and improvement systems.[207] During each BOD meeting, the QHIC reports on quality of care and services for enrollees and provides follow-up as appropriate or requested.[208]

The SCQC is the Plan's quality oversight committee for SCAL.[209] There are 15 medical centers in SCAL.[210] Each medical center has a leadership team which:

> …ensur[es] that the Quality Program addresses the quality of care, utilization management, and services provided/available to all members within their respective medical center. Each leadership team reports quality, safety, utilization, and service activities and metrics to the [SCQC], which in turn reports this information to the [BOD's QHIC].[211]

[203] *2022 Quality Program Description Southern California Region*, page 13.
[204] *Id*., page 12.
[205] *Id*., page 13.
[206] *Id*.
[207] *Id*., page 197.
[208] *Id*., page 13.
[209] *Id*., page 14.
[210] *Id*., page 9.
[211] *Id*., page 10.

The SCQC assigns responsibilities to 19 subcommittees.[212] The subcommittees are required to report to the SCQC "at least annually, or more often as necessary."[213] As required by its charter, the SCQC meets monthly, no less than 10 times per year.[214] The Department requested the monthly SCQC meeting minutes, including any and all materials provided to committee members in advance of and during the meetings. Instead of providing SCQC meeting minutes and materials, the Plan submitted documents related to NCAL's BHQOC.[215]

The Plan submitted no additional evidence the SCQC, QHIC, and BOD adequately oversaw their respective QA program responsibilties during the survey review period.

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated the "finding is based on the factually incorrect conclusion that the [SCQC] does not meet regularly." The Plan admitted it:

> …fail[ed] to produce monthly SCQC meeting minutes in response to the Department's request. Because the Department did not have copies of the meeting minutes, it determined that the SCQC, the [QHIC], and the [BOD] did not adequately oversee their respective QA program responsibilities during the survey review period.
>
> The SCQC did in fact meet monthly. The Plan produced a sampling of SCQC meeting minutes, but inadvertently identified the wrong bates numbers in its written response to the Department's request for documents. The Plan has since confirmed that SCQC met monthly (11 times per year), as required by the Rule and its charter. The Plan has also confirmed that the SCQC reported to the QHIC on a quarterly basis throughout the survey period. Those reports consisted of a one page summary, accompanied by the SCQC's complete meeting minutes. With these reports, the QHIC and BOD were able to sufficiently oversee the Plan's QA program and make improvements, as necessary.

The Plan indicated corrective action is not necessary, as the SCQC meets 11 times a year, "as required by its charter, and reports to the QHIC quarterly."

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[212] Affiliated Hospital Quality Subcommittee, Behavioral Health Quality Oversight Committee, Clinical Information Systems Quality and Patient Safety Committee, Clinical Strategic Goals Steering Committee, Regional Continuum Quality & Performance Executive Committee, Hospital Quality and Performance Executive Committee, Medi-Cal Quality Committee, Member Concerns Committee, Regional Access Committee, Regional Bioethics Committee, Regional Credentialing Committee, Regional Medication Safety Oversight Committee, Regional Patient Advisory Council, Regional Radiation Safety Committee, Regional Systems and Peer Review Oversight Committee, Regional Transplant Committee, Surgical Quality Oversight Committee, Utilization Management Steering Committee, Women's and Children's Health Leadership Team. *Id*., page 17.
[213] *Id*.
[214] *2022 Quality Program Description Southern California Region*, page 201.
[215] The BHQOC is a subcommittee of the Northern California Chiefs of Psychiatry. The BHQOC reports its activities to the QOC. *Id*., pages 14, 77.

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 18: SCQC Meeting Minutes (2019 through 2022)

Final Report Deficiency Status: Not Corrected

Based on the Plan's response and the meeting minutes provided, the Department has determined this deficiency is not corrected.

Although the SCQC meeting minutes contain references to the QHIC, the references primarily pertain to the SCQC submitting various documents to the QHIC for review and approval. There are very few MH/SUD references in the QHIC entries.[216] It is unknown what, if any, information from the SCQC the QHIC and BOD are reviewing and taking into consideration when overseeing and improving the Plan's QA program.

At the Follow-Up Survey, the Department will assess the Plan's implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, meeting minutes, interviews, and any other review deemed necessary by the Department.

STATEWIDE

Deficiency #20: The Plan does not ensure nonurgent follow-up appointments with a nonphysician MH/SUD provider are offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing MH/SUD condition.

Statutory and Regulatory References: Section 1367.03(a)(5)(F); Rule 1300.67.2.2(c)(5)(F).

Assessment: Commencing July 1, 2022, Section 1367.03(a)(5)(F),[217] and Rule 1300.67.2.2(c)(5)(F) require the Plan to ensure its network has adequate capacity and availability of licensed health care providers to offer enrollees nonurgent follow-up appointments with a nonphysician MH/SUD provider within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing MH/SUD condition.

[216] In four years of SCQC meeting minutes (2019 through 2022), only the May 24, 2019, December 6, 2019, September 24, 2021, October 22, 2021, and September 23, 2022 meeting minutes tangentially mention QHIC and MH/SUD issues on pages 130, 350, 889, 927, and 1202, respectively.
[217] Link to Senate Bill 221 (Wiener). Senate Bill 221 amended Section 1367.03 to add subdivision (a)(5)(F) to require health plans to offer enrollees nonurgent MH/SUD follow-up appointments with nonphysicians within 10 business days unless it is documented in the relevant record a longer waiting time will not have a detrimental impact on the enrollee's health.

To comply with this new 10 business day follow-up appointment requirement, the Plan developed reporting and oversight procedures for internal and external providers, which asserted:

> The Kaiser Foundation Health Plan Northern California Behavioral Health Quality Department (KFHBH) will oversee and conduct monitoring, reporting and corrective action on compliance with SB 221 for the Kaiser Permanente Northern California region. This includes monitoring, reporting and corrective action oversight on SB 221 documentation requirements for all outpatient psychiatry service areas and the clinics that make up these service areas. KFHBH will coordinate with its Southern California counterpart to keep oversight and monitoring efforts aligned.[218]

In an effort to comply with the new requirement in advance of the July 1, 2022 implementation date, the Plan formed the SB 221 Implementation Work Group in December 2021. This statewide workgroup is comprised of representatives from the Plan, TPMG, and SCPMG (e.g., regulatory services, quality, contracting, legal, etc.). The workgroup aimed to "[i]ncorporate this new standard into existing Regional Access Committee's network monitoring processes/reporting."[219] Although the workgroup met 26 times over the course of a year,[220] as of December 2, 2022, monitoring of internal and external providers remained "in process and incomplete."[221]

Plan's Compliance Effort: In response to the Preliminary Report, the Plan stated it:

> …has fully implemented monitoring of internal and external providers. In particular, with respect to internal monitoring the BHQOC's Treatment Plan Audit includes an assessment of "the quality of documentation of the initial treatment plan and interval follow-up among members who come for a new intake encounter with a KP clinician." …Similarly, the BHQOC's [EPN] Audit includes an assessment of "the quality of documentation of treatment plan, treatment goals, and interval follow-up among members who are referred to an external provider for outpatient psychiatry services."

Supporting Documentation:

- Kaiser Foundation Health Plan's Response to Nonroutine Survey Preliminary Report (October 18, 2024)
- Exhibit 19: NCAL Behavioral Health Quality Oversight Committee, Subcommittee of the Quality Oversight Committee (June 12, 2024)

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[218] *Kaiser Permanente Health Plan Behavioral Health Quality – California Senate Bill 221 Oversight*, pages 3-4.
[219] *SB 221 Timely Access to Care Implementation Summary*, page 1.
[220] The SB 221 Implementation Work Group met on December 15, 2021, January 14, 2022, January 28, 2022, February 11, 2022, March 11, 2022, March 25, 2022, April 8, 2022, April 15, 2022, April 22, 2022, April 29, 2022, May 6, 2022, May 20, 2022, June 3, 2022, June 10, 2022, June 24, 2022, July 1, 2022, July 8, 2022, July 22, 2022, July 29, 2022, August 12, 2022, August 26, 2022, September 16, 2022, October 7, 2022, October 28, 2022, November 4, 2022, and December 2, 2022.
[221] *SB 221 Implementation Workgroup Status Dashboard*, page 1.

- Exhibit 20: SCPMG Behavioral Health Retrospective Follow-up Report (January 2024)

Final Report Deficiency Status: Not Corrected

Based on the corrective actions undertaken, the Department has determined this deficiency is not corrected.

In NCAL, the BHQOC report to the QOC contained SB 221 references:

- **Treatment Plan SB 221 – NCAL Region:** Non-Detriment Documented: 65% (-8% from Q3) of treatment plans had a non-detriment statement documented when the recommended return individual visit was booked to occur past 10 business days of the initial intake date.

It is unknown whether this documentation pertains to TPMG and external contracted providers. It is also unknown whether the Plan is taking action to improve the compliance rate of documented non-detriment statements.

- **EPN Audit – SB 221 Oversight:** 2nd Visit within 10 business days: 81% (-3% from Q1) of EPN follow-up visits were booked within 10 business days of the initial intake visit.

Since the Plan measures “booked” follow-up visits, it is unknown whether external providers are offering nonurgent follow-up appointments with nonphysician MH/SUD providers within 10 business days, as required by Section 1367.03(a)(5)(F) and Rule 1300.67.2.2(c)(5)(F). In addition, the Plan did not provide this data for TPMG providers.

The Plan also provided a SCPMG Behavioral Health Retrospective Follow-Up Report. The three specialties listed are (1) Addiction Medicine and Psychiatry Non-Physician; (2) Addiction Medicine Non-Physician; (3) Psychiatry Non-Physician. However, the Plan provided no explanation what this data demonstrates.

At the Follow-Up Survey, the Department will assess the Plan’s implementation of corrective action and whether the deficiency has been corrected. Assessment may involve review of reports, meeting minutes, files, interviews, and any other review deemed necessary by the Department.

SECTION II: SURVEY CONCLUSION

The Department's 2022 nonroutine survey of the Plan is complete.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's Office of Plan Licensing, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

The Department will conduct a Follow-Up Survey of the Plan to assess outstanding deficiencies and will issue a Report within 18 months of the date of this Final Report. The Plan may elect to append a brief statement to the Final Report as set forth in Section 1380(h)(5). To append a statement, please submit the response via the Department's Survey Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

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

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2022 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.

Plan Response to The Nonroutine Final Report