



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

**FINAL REPORT**

**ROUTINE SURVEY**

**OF**

**KAISER FOUNDATION HEALTH PLAN, INC.**

**DBA KAISER PERMANENTE**

**A FULL SERVICE HEALTH PLAN**

**FEBRUARY 11, 2021**

**Routine Survey Final Report  
Kaiser Foundation Health Plan, Inc.  
DBA Kaiser Permanente  
A Full Service Health Plan**

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## **EXECUTIVE SUMMARY**

On November 16, 2018, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc. dba Kaiser Permanente (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from April 15, 2019 through April 20, 2019 in the Northern California region, and May 6, 2019 through May 10, 2019 in the Southern California region.

The Department assessed the following areas:

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

## **BEHAVIORAL HEALTH STATUS SUMMARY**

The Department identified deficiencies in the Plan's Behavioral Health Quality Assurance (QA) Program in both the 2012 and 2016 Routine Medical Surveys. On July 18, 2017, the Plan entered into a three year Settlement Agreement with the Department, which included corrective action plan deliverables. By entering into the Settlement Agreement, the Plan agreed to improve its Behavioral Health QA program and to ensure effective action was taken to improve care where deficiencies are identified, including in areas of accessibility, availability, and continuity of care. The Settlement Agreement required the Plan to engage the services of a consultant to assist and monitor the Plan's Behavioral Health QA program. The Plan and the consultant were required to work together in order to achieve the goals of the Settlement Agreement. The Plan and consultant were required to focus on six specific "Corrective Action Areas," which are described in the Settlement Agreement and summarized below:

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

During the 2016 Routine Follow-Up Survey, the Department determined that the Plan had undertaken appropriate efforts under the terms of the Settlement Agreement to begin correcting these deficiencies. The Department noted these deficiencies as pending in the Follow-Up Survey Report, which was issued to the Plan on January 30, 2019. The Plan's corrective actions noted during the Follow-Up Survey included:

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

For this 2019 Routine Survey, the Department reviewed the Plan's statewide behavioral health QA processes. Although the Department identified one QA deficiency in this 2019 Routine Survey, it is different from the behavioral health QA deficiencies noted in the 2016 Final and Follow-Up Survey Reports.

The Department's assessment included areas related to the Plan's Behavioral Health QA and its Access and Availability of Services for both Northern and Southern California. To assess Behavioral Health QA, the Department reviewed relevant Plan documents including behavioral health files involving potential quality issues (BH PQI files). Based on the BH PQI file review, the Department did not find a deficiency regarding the Plan's failure to follow-up on its corrective action plans (CAPs) intended to improve access to behavioral health appointments as noted in Deficiency #1 of the 2016 Routine Final Report.

To assess Access and Availability of Services, the Department reviewed the following documents:

- Plan policies and procedures related to Appointment Access and the Plan's Monitoring for Access and Availability of Appointments
- The Plan's Access Committee guidelines
- Internal monthly Plan tracking reports on the timeliness of initial appointments with physician and non-physician behavioral health providers for 2017-2018

Based on a review of the Plan's internal monthly initial appointments with physician and non-physician behavioral health providers tracking reports, the Department did not find a basis to cite the Plan for an access deficiency in the 2019 Routine Survey. In Deficiency #2 of the 2016 Routine Final Report, the Plan failed to provide enrollees with timely access to initial appointments for behavioral health services and failed to take

effective action when access problems were identified. In the 2019 Routine Survey, the Department found while some rates for initial behavioral health appointments with non-physician providers fell below the Plan’s internal compliance standard for multiple months, the Plan has a process for regularly tracking availability and timeliness of behavioral health initial appointments. In addition, when a particular facility fell below the Plan’s threshold for two consecutive months, the Plan took effective and timely action, as described in the Plan’s Quality Assurance Program.

Accordingly, in the 2019 Routine Survey, the Department determined the Plan has undertaken appropriate efforts to address Deficiencies #1 and #2 in the 2016 Routine Final and Follow-Up Survey Reports.

### 2019 Routine Survey Deficiencies

The Department identified **seven** deficiencies during the Routine Survey. The 2019 Survey Deficiencies Table below notes the status of each deficiency.

**2019 SURVEY DEFICIENCIES TABLE**

#	DEFICIENCY STATEMENT	
<b>QUALITY ASSURANCE (Statewide)</b>		
1	<p><b>The Plan fails to ensure that the quality of care provided is reviewed, problems are identified and effective action is taken to improve care where deficiencies are identified.</b>            Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B).</p>	<p><b>Not Corrected</b></p>
<b>GRIEVANCES AND APPEALS (Statewide)</b>		
2	<p><b>The Plan’s grievance system does not consistently monitor whether grievances are resolved in favor of the enrollee or the Plan.</b>            Section 1368(a)(1); Rule 1300.68(e)(1).</p>	<p><b>Not Corrected</b></p>
3	<p><b>The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.</b>            Section 1368(a)(1); Rule 1300.68(a)(1).</p>	<p><b>Not Corrected</b></p>
4	<p><b>For grievances involving delay, denial or modification of health care services, the Plan’s response does not describe the criteria used and clinical reasons for the decision related to medical necessity.</b>            Section 1368(a)(5); Rule 1300.68(d)(4).</p>	<p><b>Not Corrected</b></p>

	<b>UTILIZATION MANAGEMENT (Statewide)</b>	
<b>5</b>	<b>The Plan does not systematically and routinely analyze utilization data to monitor potential over- and under-utilization of services. (Statewide)</b> Rule 1300.70(a)(3) and Rule 1300.70(c).	<b>Not Corrected</b>
<b>6</b>	<b>The Plan failed to demonstrate it complies with post-stabilization care requirements. (Northern California)</b> Sections 1262.8(f)(1), 1371.4(b), 1371.4 (d), 1371.4 (j)(1), 1371.4 (j)(3), 1371.4 (j)(2)(B), (C); 1386(b)(1); Rules 1300.71.4(a), (b)(1) – (3), (d).	<b>Not Corrected</b>
	<b>PRESCRIPTION (RX) DRUG COVERAGE (Statewide)</b>	
<b>7</b>	<b>The Plan does not update its formulary on a monthly basis.</b> Section 1367.205(a)(1) to (3).	<b>Not Corrected</b>

## **SURVEY OVERVIEW**

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975<sup>1</sup> through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include a review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

**Quality Assurance** – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

**Grievances and Appeals** – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

**Access and Availability of Services** – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollee's condition and consistent with good professional practice.

**Utilization Management** – Plan and delegate utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines, that utilization review and oversight operations are performed by appropriate personnel and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials and modifications of requested services. Plans must also ensure that utilization functions satisfy access and quality requirements.

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

**Access to Emergency Services and Payment** – Each plan is required to ensure that emergency medical and behavioral health services are accessible and available, and that reimbursement for these services are made as appropriate. Plans

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

must also have post-stabilization procedures to ensure timely authorization of care or transfer of enrollees who are stabilized following emergency care.

**Prescription (Rx) Drug Coverage** – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescription drugs, benefits and services, and ensure benefit coverage is communicated to enrollees.

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

The Department issued the Preliminary Report to the Plan on May 22, 2020. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45 day response and actions for outstanding deficiencies requiring more than 45 days which will be reassessed at a Follow-Up Survey.

## **PLAN BACKGROUND**

The Plan is a non-profit, public benefit corporation and obtained its Knox-Keene license in November 1977. As of September 30, 2018, the Plan reported 8,928,407 enrollees, including 6,794,861 commercial, 136,208 Medi-Cal, and 516,570 contracted from other health plans. The Plan is a full service health care service plan providing a full range of health benefits, including prescription drug benefits and provides care through arrangements with three separate, yet closely aligned, entities. The Plan contracts with The Permanente Medical Group (TPMG) in Northern California, the Southern California Permanente Medical Group (SCPMG), and Kaiser Foundation Hospitals (KFH) statewide. TPMG is a multi-specialty physician professional corporation and SCPMG is a multi-specialty physician partnership. KFH owns and operates community hospitals and provides, or arranges for the provision of, hospital and related facility services to Plan enrollees throughout California.

The Plan's Northern California business operates in whole/part in Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties. The Plan's Southern California (SoCal) business operates in whole/part in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura Counties.

The Northern California operation has established delegation arrangements with American Specialty Health Plans of CA (ASHP), Stanford Hospitals and Clinics, The Medical Center and Medical Group at University of California San Francisco, Lucille Salter Packard Children's Hospital and pre-delegation assessment (in-progress) with Delta Dental. The Northern California operation has a delegation arrangement with Beacon Health Options of California, Inc. and a Letter of Payment Agreement, on file



with the Department, with Magellan Health, Inc. for access to behavioral health services.

The Southern California operation has an established delegation arrangement with ASHP, Children's Hospital Los Angeles Medical Group, Loma Linda University Health Care, Planned Parenthood, Rady Children's Specialists of San Diego, UCI Medical Group, UCLA Medical Group, UCSD Medical Group, USC Care Medical Group and a pre-delegation assessment (in-progress) with Delta Dental. The Southern California operation has delegation arrangements with ValueOptions of California, Inc., Windstone Behavioral Health, and PsyCare, Inc. for access to behavioral health services.

## **SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS**

On May 22, 2020, 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 within 45 days of issuance of the Preliminary Report:

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

The following 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**

#### **QUALITY ASSURANCE (Statewide)**

**Deficiency #1:      The Plan fails to ensure that the quality of care provided is reviewed, problems are identified and effective action is taken to improve care where deficiencies are identified. (Statewide)**

**Statutory/Regulatory References:** Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B).

**Assessment:** The Plan's policy, *Grievance Process for Resolution of Commercial Health Plan Member Issues*, sets forth the Plan's procedures for receipt and handling of enrollee grievances and referring grievances containing potential quality issues (PQI) to the Plan's quality department for review. The Policy states (page 12) that Program representatives<sup>2</sup> who take enrollee telephone calls create an electronic case file for each call, documenting all relevant information. The Program representatives "use Non-Clinical Screening Criteria to determine which cases need referral to Clinical Consultants<sup>3</sup> to ensure a clinical review is conducted on all member grievances that may indicate a potential quality concern." Member services staff use the *Non-Clinical Screening Criteria* tool to assess telephone call content for PQIs. Using the criteria, if the member services Program representative finds criteria are met, he or she documents the information and forwards the case to the Clinical Consultant for further review. The Clinical Consultant is responsible to review and forward the matter to the appropriate quality department if a quality issue is identified. The Program representative is also responsible to forward the grievance or appeal to the appropriate processing unit, or handle the grievance if applicable, which may be the case for some exempt grievances.<sup>4</sup> Grievances received through member services should include full

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<sup>2</sup> Program representatives are Plan member services employees.

<sup>3</sup> Clinical Consultants, or Member Services Clinical Consultants, are registered nurses employed by the Plan to review complaints for PQIs and refer the complaints to the Plan's quality department when appropriate.

<sup>4</sup> According to Section 1368(a)(4)(B)(i), grievances received by telephone, fax, email or online through a plan's website that do not involve coverage disputes, the medical necessity of health care services, or

documentation by the Program representative of the handling and/or referral of all grievance, appeal and PQI issues.

As discussed in detail below, after review of the Plan's grievance files, the Department determined:

- The Plan's Program representatives failed to identify PQIs requiring referral to Clinical Consultants, and
  - The Plan's process involving Clinical Consultants results in failure to refer all quality issues to the Plan's quality department for review, investigation, leveling and corrective action, as necessary.
- a. *The Plan's Program representatives failed to identify PQIs requiring referral to Clinical Consultants***

The Department reviewed 71 standard grievance files and found that while 35 of the 71 files contained a PQI, seven<sup>5</sup> (20%) of the 35 cases involving PQIs were not forwarded to a Clinical Consultant for review. The Department also reviewed 70 exempt grievance files and found that while 17 of these files contained a PQI, 16 cases<sup>6</sup> (94%) were not forwarded to a Clinical Consultant for review. Because the Program representative did not identify PQIs and appropriately forward these cases to a Clinical Consultant for review, cases that that should have been reviewed by the Plan's quality department were not.

### **Case Examples**

- **Standard Grievance File #36:** The enrollee complained about being discharged from inpatient rehabilitation too early and experiencing dizziness during physical therapy. The enrollee believed he was not ready to be discharged. Based on the Plan's *Non-Clinical Screening Criteria*, this complaint could involve an allegation of inadequate treatment, one of the criteria described in the tool. Because the member services representative failed to identify the PQI in this grievance, it was not forwarded to a clinical consultant for review.
- **Exempt Grievance File #2:** The enrollee complained about length of wait time in her provider's office for a mammogram. The enrollee also complained that the technician did not perform the mammogram correctly, resulting in the enrollee having to return for more scans. Based on the Plan's *Non-Clinical Screening Criteria*, this complaint could involve an allegation of inadequate treatment and improper testing. Because the member services representative failed to identify the PQI in this grievance, it was not forwarded to a clinical consultant for review.

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experimental/investigational treatments, and that are resolved by the following business day, are exempt from requirements pertaining to acknowledgement and resolution letters.

<sup>5</sup> Standard Grievance Files: File #10; File #18; File #23; File #34; File #36; File #53; and File #71.

<sup>6</sup> Exempt Grievance Files: File #1; File #2; File #3; File #8; File #9; File #15; File #17; File #21; File #23; File #25; File #31; File #43; File #46; File #56; File #58; and File #64.

The Plan's failure to consistently and accurately identify PQIs results in the Plan's inability to ensure that it identifies, reviews and corrects quality of care problems for all provider entities, or takes action to improve care where deficiencies are identified, as required by Rules 1300.70(a)(1) and 1300.70(b)(1)(B).

***b. The Plan's process involving Clinical Consultants results in failure to refer all quality issues to the Plan's quality department for review, investigation, leveling and corrective action, as necessary.***

After review of the Plan's expedited grievance files, the Department determined the Plan's process involving Clinical Consultants results in a failure to refer all quality issues received by telephone to the Plan's quality department for review, investigation, leveling and corrective action, as necessary. Rather than focusing on the quality of care issues raised during telephone calls, Clinical Consultants evaluated the enrollees' medical records and whether any actual harm occurred. In some cases, the Clinical Consultant determined the care was a matter of clinical judgment for the treating provider to make and never considered whether the care itself posed PQIs. Of the 81 expedited grievance files reviewed, the Department found that Clinical Consultants failed to appropriately refer 48 cases (59%)<sup>7</sup> to the quality department. The following files are reflective of the Plan's process.

- **Expedited File #3:** The enrollee called the Plan to appeal the decision to discharge her from a skilled nursing facility. The enrollee stated she was not strong enough to be discharged, was unable to walk and needed assistance to get around. Based on the enrollee's complaint, this case involved potential quality of care issues concerning appropriate discharge and care. The Plan expedited its review of the request to continue care at the facility and had its Clinical Consultant review the case to determine whether the case involved a quality issue. The Clinical Consultant's notes indicated review of the clinical case history and then stated the reason for not referring it for quality review: "Readiness for discharge is a matter of medical necessity decision making based on provider review of clinical data and is outside the scope of clinical consultant screening review process."
- **Expedited File #10:** The enrollee called the Plan to complain about a delay in getting a physical therapy appointment. The enrollee stated he was in severe knee pain and having lower back issues, which were new and acute. He stated when he called to make an appointment, he was advised the wait time for an appointment would be a month and a half. Based on the enrollee's complaint, this case involved potential quality of care issues concerning access to care. The Plan expedited its review of the request for a sooner appointment. The Clinical Consultant's notes indicated review of the clinical case history and then stated, in part, "No documented evidence of any adverse outcome or acute issues. Does

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<sup>7</sup> Expedited Grievance File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #10; File #13; File #14; File #16; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #26; File #28; File #29; File #31; File #32; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #42; File #43; File #49; File #52; File #54; File #57; File #58; File #59; File #60; File #64; File #66; File #67; File #69; File #71; File #72; File #73; File #75; and File #76.

not meet clinical criteria for referral to Quality based on the available documentation.”

- **Expedited File #13:** The enrollee called the Plan upset that a provider who was not her primary care provider discontinued the enrollee’s prescription without advance notice or explanation. The enrollee stated she was very upset because she had been taking the medication for seven years and “needs it for life.” Based on the enrollee’s complaint, this case involved potential quality of care issues concerning provider handling of prescriptions, provider access to prescriptions and pharmacy operations. The Plan expedited its review of the question of whether to refill the medication and authorized the request. The Clinical Consultant’s notes indicated review of the clinical case history and then stated, in part, “[The enrollee] submitted Rx refill request for [medication], which was approved that same day, medication was dispensed to [the enrollee] on November 1, 2017. No documented adverse reactions nor complications noted. Does not meet criteria for quality referral based on available documentation.”
- **Expedited File #14:** The enrollee, diagnosed with cancer, had obtained a second opinion about treatment from an out-of-network provider. The enrollee complained that her in-network surgeon scheduled surgery prematurely and that the second opinion provider stated the Plan surgeon’s proposed course of treatment was incorrect and that an MRI performed on the enrollee provided additional information indicating the Plan surgeon’s treatment plan was “all wrong.” Based on the enrollee’s complaint, this case involved potential quality of care issues concerning appropriate care and treatment. The Plan expedited its review of whether to authorize the enrollee to have surgery performed by the out-of-network provider. The Clinical Consultant’s notes indicated review of the clinical case history and then stated, in part, “Assessment, treatment/plan evident, [sic] which appear to be consistent with presenting symptoms and findings on clinical exam. No adverse outcome to [the enrollee] related to care received. Does not meet clinical criteria for referral to Quality based on the available documentation.”
- **Expedited File #35:** The enrollee sought a referral to an out-of-network provider for Botox injections to treat her chronic migraines for which she has been unable to obtain relief. The enrollee stated an outside facility informed her that the Botox injections her Plan physician was giving her in her forehead were not going to be effective and she needed the injections in the back of her head. Based on the enrollee’s complaint, this case involved potential quality of care issues concerning appropriate care and medication administration. The Plan expedited its review of whether to authorize the enrollee to have the service performed by the out-of-network provider. The Clinical Consultant’s notes indicated review of the clinical case history and then stated, in part, “Specialty referrals or outside referral are clinically driven, based on provider assessment as well as referral criteria and are not direct booking office visits. Does not meet current clinical referral criteria for referral to QA based on the available documentation.”

Clinical Consultants failed to identify and refer PQIs to the QA department for further investigation. As a result, the Plan fails to continuously review quality of care, identify

quality issues and take corrective action when necessary, as required by Rules 1300.70(a)(1) and 1300.70(b)(1)(B).

**TABLE 1**  
**Standard Grievance and Exempt Grievance File Review**

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance containing PQI	35	Review quality of care and identify quality of care issues	28 (80%)	7 (20%)
Exempt Grievance containing PQI	17	Review quality of care and identify quality of care issues	1 (6%)	16 (94%)
Expedited Grievances	81	Refer potential quality issues to the quality department	33 (41%)	48 (59%)

**Plan’s Compliance Effort:**

Program representatives failed to identify PQIs

In its response to the Preliminary Report, with respect to the finding that the Plan’s Program representatives failed to identify PQIs requiring referral to Clinical Consultants, the Plan stated it recognized the issue during the routine survey and commenced a corrective action plan to include:

- Training program representatives to review the *Non-Clinical Screening Criteria* document, the *Potential Quality of Care Review Process* document and the *End-of Business Day grievance case processing* document.
- Focused web-based refresher training covering the Non-Clinical Screening Criteria and exempt grievance processes, beginning in August 2020, to be completed no later than September 2020; and
- A Q4 2020 audit to review a random sample of 75 standard grievance files to determine whether PQIs were appropriately referred to the Clinical Consultant using the Non-Clinical Screening Criteria. Also, the Plan will review a random sample of 30 exempt grievances to ensure no PQIs were identified, using a compliance threshold of 95%.

The Plan, however, disputed seven of the 23 files the Department identified as deficient, stating the seven files do not contain PQIs under the *Non-Clinical Screening Criteria* because the grievances involved quality of service, privacy or concerns other than quality of care.

With respect to the finding that use of Clinical Consultants results in failure to refer all quality issues to the Plan's quality department, the Plan stated its Regional Quality Physician Leads and nurses reviewed the 48 expedited grievances identified as deficient and found 46 were handled properly as they did not meet the *Clinical Screening Criteria*. The Plan provided two example cases and explanations for why the Plan believed the two cases did not need to be referred for quality review. Based on the two expedited grievance files the Plan agrees should have been referred for quality review, the Plan described the following corrective actions:

- Mandatory training for Clinical Consultants and Physician Advisors on June 18, 2020 which included review of the two cases that should have been referred; and
- A Q4 2020 audit involving a random selection of 30 grievance files to determine whether the Clinical Consultant's decision to refer PQIs to the Quality Department is consistent with the *Clinical Screening Criteria*. The Plan will apply a compliance threshold of 95%.

The Plan further stated the initial *Clinical Screening Criteria* was developed with the approval of the Department as part of the 2006 Non-Routine Quality Survey CAP.

**Supporting Documentation:**

- *Non-Clinical Screening Criteria* (August 21, 2014)
- Plan training document entitled: "CAMS Potential Quality of Care Review Process"
- Plan training document entitled: "Video Scripts: CAMS Potential Quality of Care Review Process"
- Non-Medicare End of Next Business Day (ENB) Criteria: Local Member Services New Hire Training (February 2019)
- Mandatory Training Attendees
- Validation Audit Tool for Deficiency 2.1 (Standard Grievance and Exempt Grievance)
- *Complaints Referred to the Quality Department*, Policy Number CA.SCQC.QOC.001 (revised January 1, 2017)
- Training attendees document "DMHC audit case reviews with MD Advisors" (June 18, 2020)
- Validation Audit Tool for Deficiency 2.2
- Plan document entitled "2019 DMHC Routine Medical Survey and Behavioral Health Survey – Southern California DMHC On-Site Document Requests (May 7, 2019)
- 2006 Final Report of the Non-Routine Medical Survey of Kaiser Foundation Health Plan, Inc. (Issued to the Public July 26, 2007)
- 2010 Follow-Up Review Report for a Non-Routine Medical Survey of Kaiser Foundation Health Plan, Inc. (Issued to the Public July 19, 2010)

**Final Report Deficiency Status: Not Corrected**

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

### Program representatives failed to identify PQIs

The Department finds the Plan initiated corrective action with respect to identification of PQIs, but the corrective action is not reasonably calculated to correct the deficiency. The Plan identified seven of the 23 files reviewed as not deficient on grounds the seven files do not contain PQIs in accordance with the *Non-Clinical Screening Criteria*. The Plan takes the position that because the grievances involved quality of service, privacy issues or concerns other than quality of care, the cases did not merit investigation for quality problems. Therefore, the Plan's corrective action of providing training and monitoring files is not reasonably calculated to correct the deficiency because it does not address the reason the Plan does not identify all PQIs.

The seven cases involved grievances about provider mishandling of protected health information, provider conduct such as being rude or disrespectful and access problems that delayed care. The Plan must assess whether the nature of these grievances bear directly on care provided to enrollees, even if the actions themselves do not constitute a health care service. Providers who are rude and disrespectful to patients may be at risk for not providing quality care because they are more likely to disregard patient concerns. Mishandling of PHI can result in unintended disclosure of personal or private information and may deter enrollees from seeking care. Access issues and delayed care directly contribute to exacerbation of enrollee health problems. Thus, the Plan's failure to send to its quality department any cases except those involving direct patient care results in the Plan's failure to identify, review and correct all quality issues for all provider entities, as required by Rules 1300.70(a)(1) and 1300.70(b)(1)(B).

Additionally, the *Non-Clinical Screening Criteria* identify issues other than direct care for review by the quality department. The criteria include: "Any allegations of failure to treat ... inadequate access that member alleges is/will impact the member's health ... nearly receiving the incorrect treatment ... any allegations of unprofessional conduct or criminal activity, inappropriate behavior." Thus, the *Non-Clinical Screening Criteria* does not support the Plan's conclusion that it acted appropriately by not forwarding for quality review files that contained allegations of poor quality of service, privacy or issues other than quality of care.

### Clinical Consultants Failed to Forward Cases Requiring Quality Review

With respect to the issue of Clinical Consultants not forwarding expedited grievances to the Plan's quality department, the Plan responded it found 46 of the 48 identified cases were handled properly as they did not meet the *Non-Clinical Screening Criteria*. The Plan provided the following two cases examples to explain why the cases did not meet the *Non-Clinical Screening Criteria*. For Expedited File #13, the facts of which are described above, the Plan stated that because "Plan records clearly reflect a timely, same-day response and fulfillment of the enrollee's first noted request for refill [and t]he enrollee's allegation is not supported by the medical record, [t]his case did not meet the Plan's Clinical Screening Criteria."

The second case is Expedited File #69. In that case the daughter of an elderly enrollee took her mother, who resided at an assisted living facility, to the emergency room when her mother began having hallucinations, loss of appetite, increasing combativeness,



inability to walk and overall declining health. Following intravenous hydration and treatment for a urinary tract infection, the ER sought to discharge the enrollee. The daughter wanted the hospital to keep her mother overnight for observation because the enrollee's legs were swollen and she was unable to walk. The daughter claimed her request was met with yelling, verbal abuse and verbal aggression by hospital staff including a nurse, a case manager and a social worker.

The Plan reasoned it was appropriate not to refer the matter described in Expedited File #69 for quality review based on the outcome of the case. The Plan stated, "[a]llegations related to perceived untimely discharge would generally be referred to Quality if the member returns for further evaluation of a same or similar condition within 72 hours OR if the member experiences an adverse event following the discharge that may be objective evidence that the member may not have been truly stable for discharge."

For both Expedited File #13 and #69, the Plan must focus on the potential risk of harm to the enrollee rather than the outcome. Poor quality of service can adversely impact care. Quality assurance programs must therefore be designed to ensure appropriate care is not withheld or delayed and plans must monitor and evaluate care to ensure, for each enrollee, care provided meets professionally recognized standards of practice. (See Rules 1300.70(b)(1)(A), 1300.70(b)(1)(D), 1300.70(b)(2)(C)) To accomplish these requirements, Rules 1300.70(a)(1) and 1300.70(b)(1)(B) require plans to review the quality of care provided, identify problems and take effective action to improve care when deficiencies are identified for all provider entities. Quality programs must address not only health care services, but also service elements, including accessibility, availability and continuity of care. (Rule 1300.70(a)(3)).

As a consequence of the Clinical Consultants' failure to refer quality incidents, the Plan does not review the quality of the care or service that was provided. The Plan misses the opportunity to assess whether the provider's actual care, service, or failure to provide care, or error in care or service, regardless of the outcome, was a quality issue that required review and correction. Simply because there was no adverse outcome, does not necessarily mean the care or service was appropriate.

Because the Plan's response to the Preliminary Report demonstrates a misapplication of the *Non-Clinical Screening Criteria* and erroneous construction of the requirements of Rules 1300.70(a)(1) and 1300.70(b)(1)(B), the Department finds the Plan's corrective action is not reasonably calculated to correct the deficiency.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of Plan policies and procedures, applicable desk aids, training materials, audits, and other relevant documents. The Department will also review grievance files and conduct interviews with Plan staff.

## **GRIEVANCES AND APPEALS (Statewide)**

**Deficiency #2:      The Plan's grievance system does not consistently monitor whether grievances are resolved in favor of the enrollee or the Plan. (Statewide)**

**Statutory/Regulatory References:** Section 1368(a)(1); Rule 1300.68(e)(1).

**Assessment:** Section 1368(a)(1) requires plans to have reasonable procedures in accordance with Department regulations to ensure adequate consideration of grievances and rectification when appropriate. Rule 1300.68(e)(1) requires plan grievance systems to track and monitor grievances, including the number of grievances received and resolved, and whether the grievance was resolved in favor of the enrollee or the plan.

During interviews, the Department asked the Plan to describe its method for monitoring and tracking whether grievances were resolved in favor of the enrollee or the Plan.

The Plan responded that it monitors this through “Request codes,” assigned within the Plan’s system: Complaint Integrated Workflow and Reporting System (CIWRS). The Plan stated that the CIWRS system assigns Request codes only when an enrollee makes a request for specific Plan action.

The Department asked the Plan to clarify what it would consider a specific enrollee request and the Plan stated a request for payment or a request for a service, for example, would be assigned a Request code. Further, the Plan confirmed grievances that do not include a specific enrollee request, would not be assigned a Request code. As such, the CIWRS system does not track every grievance by an assigned Request code, and the Plan is unable to monitor all grievances for whether the resolution was in favor of the enrollee or the Plan.

**Plan’s Compliance Effort:** In its response to the Department, the Plan stated it initiated corrective action including:

- Use of systemic categorization to capture the nature of resolution for each grievance;
- Training for Program representatives
- Implementing a field in the Plan’s electronic record system to include dropdown options to indicate whether the grievance was decided in favor of the enrollee, partially in favor of the enrollee or in favor of the Plan. The change is expected to be implemented and training completed by Q4 2020.

**Supporting Documentation:**

- Validation Audit Tool

**Final Report Deficiency Status: Not Corrected**

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

The Department finds the Plan initiated corrective action but requires additional time to complete implementation. At the Follow-Up Survey, the Department will assess the Plan’s corrective actions, review training materials and a demonstration of the Plan’s revised electronic system of record, as well as conduct interviews and review any other relevant information to determine whether the deficiency has been corrected.

**Deficiency #3:**     **The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate. (Statewide)**

**Statutory/Regulatory References:** Section 1368(a)(1); Rule 1300.68(a)(1).

**Assessment:** Section 1368(a)(1) requires plans to have reasonable procedures in accordance with Department regulations to ensure adequate consideration of grievances. Rule 1300.68(a)(1) defines a grievance as “a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.”

Plan policy *Grievance Process for Resolution of Commercial Health Plan Member Issues* defines the term Grievance on page 24:

**Grievance:** Within the KFHP 30-day Grievance process specified by Knox-Keene, any expression of dissatisfaction for which the member or his/her duly authorized representative seeks referral, provision of or reimbursement for services or supplies, or other financial resolution, that does not constitute an Initial Benefit Claim, regardless of how that dissatisfaction is submitted to KFHP.

The Department reviewed 71 call inquiry files and found that 12 files<sup>8</sup> (17%) included calls that contained an expression of dissatisfaction or a request for reconsideration that the Plan did not handle as a grievance.

### **Case Examples**

- **File #14:** The enrollee stated he needed a doctor’s note for work because the enrollee had a heart attack, but the doctor was unresponsive to his requests.
- **File #22:** The enrollee stated she received a bill she believed was miscoded. The enrollee stated she went for a routine visit and a pap smear was done. She believed there should not be an extra charge. The enrollee further stated she had received a reminder from the Plan to get the pap smear. However, after the visit, the Plan denied the claim, stating the enrollee was not yet due for a pap smear.
- **File #78:** The enrollee called and stated she wished to file a grievance over her deductible amount.

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<sup>8</sup> Call Inquiry Files: File #10; File #14; File #22; File #33; File #43; File #58; File #62; File #63; File #66; File #67; File #70; and File #78.

The Department determined that the Plan’s failure to identify all grievances in telephone calls results in the Plan not adequately considering, investigating and resolving all grievances raised by enrollees.

**TABLE 2**  
**Call Inquiry File Review**

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Member Service Inquiry	71	Expressions of dissatisfaction, or requests for reconsideration must be processed as grievances	59 (83%)	12 (17%)

**Plan’s Compliance Effort:** In its response, the Plan stated it initiated the following corrective action:

- Since July 2019, Plan conducted seven trainings for its customer service representatives using alerts and communications to provide guidance on identifying oral expressions of dissatisfaction as a grievance. Trainings included review of *Handling Complaints Alert* and *Filing a Complaint Job Aid* documents.
- In July 2019, the Plan reviewed the deficient calls, identified and provided training to staff who needed one-to-one coaching.
- In November 2019, new hire training materials were revised to ensure staff identify oral expressions of dissatisfaction as grievances.
- An online training refresher, *Inquiries vs Grievances*, is to be provided to all staff by September 30, 2020, and will be required annually thereafter.
- The Plan will perform an audit in Q4 2020, reviewing a sample of 100 inquiry files to determine whether cases were properly classified as inquiries. The Plan will use a compliance standard of 95%.

The Plan disputed three<sup>9</sup> of the 14 files the Department identified as deficient, finding the calls involved inquires and not grievances.

**Supporting Documentation:**

- Plan training alert: “Handling Complaints”
- Job Aid: “Filing a Complaint”
- Team Meeting Log (July 2019)
- Plan document “July 2019 Internal Coaching Opportunities”
- Plan training document: “Complaint Handling: Participant Guide”
- Validation Audit Tool

<sup>9</sup> File #1, File #15, File #43.

## Final Report Deficiency Status: Not Corrected

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

The Department re-reviewed the three files disputed by the Plan. The Department agrees Inquiry File #1 and #15 were properly categorized by the Plan as inquiries and not grievances. However, File #43 was a call from an enrollee who, after calling Covered California twice and the Plan at least twice, was still trying to get the coverage and premium billing issues for her daughter and grandson corrected. The enrollee was clearly exasperated, and the Department determined this was a grievance about Plan processes. Although Inquiry File #1 and #15 are not deficient, and the written deficiency has been revised accordingly, the Plan remains deficient.

The Department finds the Plan initiated corrective action but requires additional time to complete implementation. At the Follow-Up Survey, the Department will assess the Plan's corrective actions, training materials, audit results and will conduct file review and interviews with Plan staff, as well as review of any other relevant information.

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**Deficiency #4:** For grievances involving delay, denial or modification of health care services, the Plan's response does not describe the criteria used and clinical reasons for the decision related to medical necessity. (Statewide)

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

**Assessment:** Section 1368(a)(5) requires plans to provide "written responses to grievances with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan's written response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity." Rule 1300.68(d)(4) states that for grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan's written response "shall clearly state the criteria, clinical guidelines or medical polices used in reaching the determination."

Plan policy *Grievance Process for Resolution of Commercial Health Plan Member Issues* sets forth the Plan's resolution letter requirements for standard grievances and appeals. The policy states on page 28:

### **3. Resolution Letter Requirements (Grievances and Appeals)**

Resolution letters will be sent within 30 calendar days following receipt of the Grievance or Appeal and contain the following: ...

- a) The outcome of all issues and an explanation of the decision, stated in a clear and concise manner....
- b) If applicable, the specific reasons for the denial ...

- c) If applicable, a statement that the member's issues were shared with the responsible management or supervisory staff for review ...
- d) Any/all follow-up information to assist the member with the next steps ...
- e) For medical necessity denial letters, the criteria, guidelines or protocols used and the clinical reasons for the determination based on physician review.
  - i. If the decision is based upon a specific criterion, guideline or protocol, identify the criterion, guideline or protocol in sufficient detail including a clear and concise clinical explanation as to why the member does not meet the criterion, guideline or protocol. If appropriate, the letter should tell the member any actions that the member needs to take to meet the criteria, guideline or protocol.  
OR
  - ii. If the decision is not based on a specific criterion, guideline, or protocol, the letter must state that the decision was made based on the physician's professional medical judgment. It must also state the clinical reasons for the denial in clear and concise language so that the member knows the specific basis for the physician's denial, including the specific clinical information provided by the physician reviewer and any clinical recommendations for follow-up. It is not sufficient to say the requested service is "not medically necessary". The Program representative must provide the rationale in the letter.
- f) For benefit denial letters, specific provisions in the contract or evidence of coverage that exclude the coverage  
OR  
If the decision is based on a benefit or provision or contractual obligation, insert the document name and page ...

The Plan's policy, *Grievance (Urgent, Rx Formulary Exceptions and Rx IRO Requests) Process and Resolution of Commercial Health Plan Member Issues* sets forth the same requirement for expedited grievances and appeals.

The requirements in Section 1368(a)(5) that apply to "grievances involving the delay, denial or modification of health care services" require a plan's response to describe the criteria used and clinical reasons for the decision. A grievance is a complaint or request for reconsideration. Therefore, when a grievance involves a complaint that care was denied, modified or delayed, or involves a request for reconsideration, a plan's response letter must state the criteria used and clinical reasons for the plan's decision.

The Plan's policy directs resolution letters must state the criteria used and clinical reasons for the decision when the Plan has issued a medical necessity denial letter. However, the Plan sends medical necessity denial letters only in connection with provider requests for services requiring prior authorization, and the Plan requires prior authorization for only a handful of services. This means an enrollee who complains a service was modified, such as a reduction in frequency of treatment sessions, may not be provided the clinical criteria upon which the Plan determined the prior frequency of service is no longer medically appropriate. The Plan need only provide its reason, under paragraph (b) of its policy set forth above. When an enrollee complains they were denied a service, the Plan need only support its conclusion the service is not medically

appropriate by saying the Plan's physician reviewer determined the care is not appropriate.

Section 1368(a)(5) does not limit grievance response letter requirements to only those situations involving a denial letter. Plans must consider the content of the grievance itself since the requirement pertains to *grievances* involving delay, denial or modification of health care services and not a *plan's* delay, denial or modification of services.

Moreover, the Plan's policy makes a further distinction between medical necessity denial letters based on a criteria/guideline or protocol versus the Plan physician's professional medical judgment. In the latter case, the Plan limits the grievance response letter content to "the clinical reasons for the denial ... so that the member knows the specific basis for the physician's denial." Section 1368(a)(5) does not exempt "medical judgment" decisions from the requirement that grievance response letters include the criteria or guidelines when a grievance involves delay, denial or modification of health care services. The Plan's policy makes a distinction not contemplated by the Knox-Keene Act, and results in deficient response letters being sent to enrollees.

The Department reviewed 71 standard grievance files. Seven<sup>10</sup> of the 71 files involved grievances pertaining to denial, delay or modification of health care services. None of the grievance response letters in the seven files contained a description of the criteria or clinical reasons for the Plan's decision, although the Plan determined the services were not medically necessary.

The Department reviewed 70 expedited grievance files, of these, 34<sup>11</sup> involved grievances pertaining to the denial, delay, or modification of health care services. None of the grievance response letters in the 34 files contained a description of the criteria and clinical reasons for the Plan's decision, although the Plan determined the services were not medically necessary.

### **Case Examples**

- **Standard Grievance File #11:** The enrollee requested an out-of-network referral, stating he asked his doctor for a referral and received a denial via e-mail. The Plan's response stated:

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

Your request for an out of Plan referral for annual MP [multiparametric] MRI for Active Surveillance, at the UCLA Medical Center was determined to be not medically indicated at this time.

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<sup>10</sup> Standard Grievance Files: File #9; File #11; File #33; File #36; File #49; File #54; and File #61.

<sup>11</sup> Expedited Grievance Files: File #1; File #2; File #3; File #6; File #7; File #8; File #11; File #12; File #14; File #19; File #21; File #22; File #23; File #24; File #26; File #27; File #28; File #33; File #34; File #35; File #37; File #38; File #39; File #41; File #45; File #49; File #55; File #56; File #57; File #59; File #65; File #66; File #68; and File #69.

The Member Case Resolution Center will assist with further follow-up in the urology department. Per the reviewing physician, the current information in the literature is not sufficient to support a role for repeat MRI without prostate biopsy for monitoring men on active surveillance for prostate cancer. If you need my assistance in obtaining a follow-up appointment in the Urology Department, I can be reached at the phone number listed below.

Your concern was sent to the Chief of Service of the Urology Department, for review and action as deemed appropriate.

On September 29, 2017, the Chief of Service reviewed your request and explained that the technology is available within the organization. However, the current information in the literature is not sufficient to support a role for repeat MRI without prostate biopsy for monitoring men on active surveillance for prostate cancer. The American Urological Association has recently published a Policy statement on the use of MP MRI in diagnosis, staging and management of prostate cancer. The recommendation to have an annual MRI is not evidence based.

The enrollee's grievance included a statement of dissatisfaction concerning his doctor's denial of his request for an out-of-network referral. The Plan's response letter stated the service was not medically necessary,<sup>12</sup> but did not include a description of the criteria, clinical guideline or medical policy that the Plan relied on in determining that the requested service was not medically necessary. "Current information in the literature," cited by the Plan, is not a criteria, guideline, or medical policy. Further, while the letter vaguely cited to an American Urological Association Policy statement, this is not a clinical criteria or guideline, but appears to be taken from a journal article.<sup>13</sup> Additionally, the statement concerning "men on active surveillance for prostate cancer" appears to reference the enrollee's condition, and is not a clinical reason for denial related to medical necessity.

- **Standard Grievance File #61:** The minor enrollee's mother telephoned the Plan grieving the fact that her son's speech therapy was "cut" from twice a week to one time per week sessions, and requested reconsideration of twice weekly therapy. The Plan's response stated in part:

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

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<sup>12</sup> The Department notes the Plan uses terms such as "medically indicated" rather than "medically necessary" as is used in Section 1368a)5), but the Department finds the distinction negligible and one of semantics.

<sup>13</sup> See Fulgham et al., *AUA Policy Statement on the Use of Multiparametric Magnetic Resonance Imaging in the Diagnosis, Staging and Management of Prostate Cancer* Oct. 2017) J. Urol. and available online at [PubMed.gov](http://PubMed.gov).



In consultation with the Speech Language Pathologist Supervisor, the following individuals met as a committee to discuss and evaluate your request:

- Physician Reviewer, Developmental Pediatrician
- Physician Reviewer, Developmental Pediatrician

The committee determined that, based on the results of [your child's] April 20, 2018, speech therapy evaluation, it is not medically indicated for him to receive speech therapy twice per week at this time. There is no evidence that increasing the frequency of speech therapy yields better results. The committee also explained that he previously was receiving speech therapy twice per week due to an additional diagnosis of Childhood Apraxia of Speech (CAS). His most recent evaluation showed he no longer has CAS.

Please note that this denial is based on the terms and conditions of your agreement with Kaiser Permanente, as set forth in the 2018 Evidence of Coverage ... [which] states that we cover the services described in the "Benefits and Your Cost Share" section, only if the services are medically necessary and prescribed by a Plan Physician.

In this case, the grievance pertained to modification of services involving reduction of speech therapy sessions. While the Plan determined twice weekly therapy sessions were not medically necessary, the Plan's letter failed to provide a description of clinical criteria used to make the determination, or state the clinical reasons for the modification, including why or how a diagnosis of CAS relates to medical necessity of one additional session per week of speech therapy. The Plan cited its EOC as the basis of its decision, a document used to cite coverage or benefit denials and not medical necessity determinations.

- **Expedited Grievance File #2:** The enrollee requested an MRI from her doctor because she was experiencing numbness, distorted thinking, headaches and tingling. Her physician contacted the neurology department and then told the enrollee that a neurologist denied the enrollee's ability to get an MRI because the MRI she had three years earlier was normal. The enrollee requested a second opinion and her physician contacted a second neurologist, reporting to the enrollee that the second neurologist's conclusion was the same as that of the first neurologist. The enrollee called the Plan to request reconsideration for an MRI. The Plan's response to the enrollee's grievance stated:

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

An Associate Medical Director has determined that your above request is not medically indicated for your condition at this time.

A review of your medical records indicate that an in-person office visit is necessary in order to evaluate your symptoms and determine the appropriate care going forward.

It is recommended that you have an evaluation in the Neurology Department with Dr. [ ] or a second opinion with another neurologist....

This denial is based on your agreement with Kaiser Permanente through Kaiser Permanente for Individuals and Families. In your 2017 Evidence of Coverage (EOC) under section, "Benefits and your Cost Share," it states that Kaiser Permanente only covers services that are medically necessary and provided, prescribed, authorized, or directed by a Kaiser Permanente plan doctor. This information can be found on page 21. If you would like a copy of the referenced EOC pages, at no charge, please contact me at the telephone number below.

The Plan's response letter included a finding that the services were not medically necessary, but deemed an in-office neurology appointment to be necessary. The letter did not include a description of criteria, clinical guideline or medical policy the Plan reviewer relied upon to determine that the requested service was not medically necessary. The letter's reference to the Enrollee's EOC is insufficient as a citation to a criteria, clinical guideline or medical policy. Additionally, the letter did not include the clinical reasons related to medical necessity. Further, despite the fact that the enrollee's grievance stated her physician contacted two neurologists<sup>14</sup> (for a first and then second opinion) who both gave the same response, the Plan's resolution was to state she needed a "second opinion evaluation," without providing a reason for this decision.

- **Expedited Grievance File #19:** The enrollee called to grieve about her physician, who she said told her that Kaiser found Lorazepam "doesn't really help." The enrollee wanted to continue use of the medication or else the medication would need to be tapered off and not stop use immediately. She complained her physician did not offer another medication. The enrollee also requested assignment to a different doctor. The Plan's response to the enrollee's grievance stated, in part:

We're sorry, but we have denied the following request:

- A full prescription of Lorazepam (Ativan)  
An Associate Medical Director reviewed your request and denied it as not medical needed [*sic*] at this time.

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<sup>14</sup> The enrollee's physician did not refer the enrollee to the neurologist in the first instance, but used his professional judgment to obtain phone consultations from the neurologists. The Plan determined that appropriate care included an in-person consultation with a neurologist. The Plan does not have a process for monitoring widespread use of professional physician judgment in making medical necessity determinations beyond peer review and grievances, and this case is demonstrative of the problem with that practice.

Your medical records show you were evaluated and the recommendation to reduce the number of pills per prescription refill to allow a gradual self [sic] to taper off the medication over many months [sic] time.

Our recommendation is that you have monthly or every two-month check by phone while tapering.

To learn more about why this decision was made, please refer to your July 1, 2017, through June 30, 2018, Inland Empire Health Plan Evidence of Coverage (EOC). Under section "Benefits," it states:

"You can get covered services only if you are a member on the date that you get the services and the services are medically necessary. Most services listed in this section are covered only if:

- A Kaiser Permanente plan doctor provides, prescribes, directs, or authorizes the services
- You get the services from Kaiser Permanente plan providers in the Kaiser Permanente service area, and
- The Medical Group has authorized the services if the services require Medical Group authorization (see "Medical Group Authorization Process for Some Referrals" in the "How to Get Care" section to find out what services need Medical Group authorization)" (p.36)

Please also refer to the "Terms You Should Know" section of the EOC where it defines "medically necessary" as:

"Services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to relieve severe pain, through the diagnosis or treatment of disease, illness, or injury."

The Plan's letter stated a Plan Medical Director determined the medication was not medically necessary. However, the letter failed to describe any clinical criteria or guideline used to make the medical necessity determination or the reasons related to medical necessity. The letter cited to a section of the EOC as the basis for the determination, which is the appropriate citation for a benefit/coverage denial, but not for a grievance alleging denial of covered, medically necessary services, as required by Section 1368(a)(5).

- **Expedited Grievance File #55:** The enrollee requested a refill of Adderall. The Plan's response states:

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

Our Associate Medical Director determined that it is not medically necessary at this time. It was noted that you were informed by Dr. [ ] at the San Francisco Medical Center Psychiatry Department on October 25, 2017, that you will need to be assessed for Attention Deficit Hyperactivity Disorder

(ADHD) and provide your previous medical records prior to receiving a refill of Adderall. It is recommended that you schedule an appointment to be evaluated to determine the appropriate treatment plan and prescription medications to manage your condition.

Mr. [ ], in an effort to provide you with the best service possible, I attempted to contact you on October 26, 2017, however, I unfortunately, was unable to reach you to schedule an appointment, please contact the San Francisco Medical Center Psychiatry Department at [ ]. If you would like assistance scheduling an appointment you may contact me at the telephone below.

This denial is based on your agreement with Kaiser Permanente through [employer name]. In your Year Evidence of Coverage (EOC) under section, "Benefits and your Cost Share," it states that Kaiser Permanente only covers services that are medically necessary and provided, prescribed, authorized, or directed by a Kaiser Permanente plan doctor. This information can be found on pages 20 and 21. If you would like a copy of the referenced EOC pages, at no charge, please contact me at the telephone number below.

The Plan's response letter found the requested medication to be "not medically necessary" but then stated in the same sentence the enrollee would need to be assessed for ADHD "prior to receiving a refill" of the requested medication. The sentence self-contradicts because the Plan denies the request as not medically necessary, but then suggests the enrollee might get a refill. Also, the letter lacks a description of the criteria, clinical guideline or medical policies that the Plan relied upon to determine that the requested service was not medically necessary.

The letter fails to include a clinical reason related to medical necessity and the reference to the Enrollee's EOC is insufficient as a citation to a criteria, clinical guideline, or medical policy.

**TABLE 3**  
**Standard Grievance and Expedited Grievance File Review**

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance involving a delay, denial or modification of health care services	7	Plan's response describes the criteria or guideline used and clinical reasons for its decision.	0 (0%)	7 (100%)

Expedited Grievance involving a delay, denial or modification of health care services	34	Plan's response describes the criteria or guideline used and clinical reasons for its decision.	0 (0%)	34 (100%)
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**Plan's Compliance Effort:** In response to the Preliminary Report, the Plan disagreed with the Department's findings. The Plan stated because it does not conduct utilization management or prior authorization for most services, it "does not maintain rigid criteria" that apply to most services. Enrollees who disagree with their physicians' clinical judgment "may use the Plan's grievance process as an avenue to seek reconsideration as to whether the services are medically necessary or appropriate." The Plan stated clinical judgments can be made first by the treating provider or as part of the grievance process. While the Plan "strongly supports the practice of evidence-based medicine" the Plan stated "these guidelines are non-binding [and] in areas where the Plan does not require prior authorization/utilization management, there are no criteria/checklists that are applied when members disagree with the judgment of their treating physician."

With its response, the Plan identified three grievance files<sup>15</sup> the Department identified as deficient involving requests for out-of-network referrals and stated, "There are no criteria upon which to base a disease-specific request to go out-of-Plan.... Any criteria to be used to determine whether the requested care (in - or out-of-Plan) is appropriate would be irrelevant, since the Plan is offering the requested care in Plan." The Plan provided another file<sup>16</sup> as an example of files "the Plan believes it provided sufficient clinical explanations to satisfy the applicable requirement."

Finally, the Plan stated it ensures consistency in decision-making by using an interrater reliability (IRR) process which "allows Member Relations leaders to ensure that corrective measures are instituted, as needed, to assist with the development and improvement of the consistency and reliability of clinical decisions."

**Supporting Documentation:**

- The Plan submitted no documents in response to this deficiency.

**Final Report Deficiency Status: Not Corrected**

The Department determined this deficiency is not corrected.

The Plan disputed this deficiency on two bases. First, the Plan disputed the deficiency on the basis that the Plan does not require use of criteria to determine the medical necessity of most services, either by the treating provider or by the Plan in reviewing grievances. Second, the Plan's review of the deficient files concluded no criteria are

<sup>15</sup> Standard Grievance File #9 and Expedited Grievance File #35 and #65.

<sup>16</sup> Expedited Grievance File #23.

necessary or applicable to grievances regarding denied out-of-network services, and most other grievance resolution letters included “sufficient clinical explanation.”

While the Plan may not conduct utilization management or require prior authorization for most services, and therefore not require use of clinical criteria, the Plan is not exempt from the requirements of Section 1368(a)(5) and Rule 1300.68(d)(4). When a plan reviews a grievance involving delay, denial or modification of services based on a determination in whole or in part that the service is not medically necessary, the plan’s response must state the criteria, clinical guideline or medical policy used in reaching the determination. While Section 1368(a)(5) and Rule 1300.68(d)(4) also require the clinical reasons to be stated in the response, the reasons for the denial are a separate requirement from the requirement for criteria, clinical guideline or medical policy.

The Plan’s response asserted there “are no criteria” applicable to requests to go out-of-network. The Department disagrees. Rule 1300.67.2.2(c)(7)(B) includes a requirement that “Plans shall arrange for the provision of specialty services from specialists outside the plan’s contracted network if unavailable within the network, when medically necessary for the enrollee’s condition.” In the three out-of-network grievance files identified by the Plan, the enrollees sought care from out-of-network providers based on assertions that in-network services were not available.

In Standard Grievance File #9, the enrollee stated his particular tumor was first misdiagnosed by a Plan physician, who then told the enrollee no surgery was necessary and the enrollee could only see an ENT (ears, nose and throat) specialist, not a neurologist or other neurosurgeon. The enrollee believed a neurologist or specialist other than an ENT was not available to him.

In Expedited Grievance File #35, the enrollee sought out-of-network Botox injections to the back of her head to treat her severe migraines. Although she received several treatments including Botox to her forehead from Plan physicians, no treatment in network had been effective and the enrollee was told the Plan only performed Botox injections to the forehead, not the back of the head. Thus, the enrollee believed the services she requested and were denied were not available in network.

In Expedited Grievance File # 65, after the enrollee had both hips operated on by a Plan physician, she continued to suffer hip pain on one side. Her treating physician said he did not shave enough bone off the first time. Another Plan physician said he could perform the corrective surgery, but there was a 6-month wait list. The enrollee believed the needed treatment was not available timely, and the out-of-network physician was able to perform the surgery within two weeks.

Because Rule 1300.67.2.2(c)(7)(B) requires plans to arrange for out-of-network specialty services when not available in-network and medically necessary for the enrollee, there are circumstances in which out-of-network requests must be reviewed for medical necessity. In such cases, grievance response letters must include the criteria or guideline used and the reasons related to medical necessity, as required by Section 1368(a)(5) and Rule 1300.68(d)(4).

Finally, while the Plan believes it provided “sufficient clinical explanations to satisfy the applicable requirement” in other grievance cases, the Plan conflates the two distinct requirements of providing criteria (or guideline or medical policy) and clinical reasons to explain the Plan’s decision. As discussed above, the Plan is not exempt from including both required components in grievance resolution letters when grievances involve a delay, denial or modification of services based in whole or in part on medical necessity.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a corrective action plan that addresses all elements of this deficiency, and provide a status report on the Plan’s compliance efforts.

At the Follow-Up Survey, the Department will assess the Plan’s corrective action, including review of any revised policies and procedures, a review of grievance files, and any other relevant documents. The Department will also conduct interviews with Plan staff.

### **UTILIZATION MANAGEMENT Statewide**

**Deficiency #5:       The Plan does not systematically and routinely analyze utilization data to monitor potential over- and under-utilization of services. (Statewide)**

**Statutory/Regulatory References:** Rule 1300.70(a)(3) and Rule 1300.70(c).

**Assessment:** The Plan’s *Northern California Region 2018 Utilization Management (UM)/Resource Management Program Description (UM/RM Program)* includes a section entitled “Monitoring Under and Over-Utilization” on pages 13 and 14. This utilization monitoring section addresses only three types of services: Laboratory Services, Radiology/Diagnostic Imaging Services and Pharmacy Services. For laboratory services and radiology/imaging services, the policy states the Plan utilizes specific committees, including the Laboratory Utilization Committee and Radiology/Diagnostic Imaging Utilization Committee, respectively, to coordinate the efforts of the medical centers to develop and evaluate best practices. With respect to both laboratory and radiology/imaging services, the policy states TPMG personnel are “directly responsible for R[esource] M[anagement] ... including monitoring, evaluation of services and taking necessary action.” The policy, however, does not describe how or when monitoring or evaluation are performed, or when “necessary action” is required or what that action might entail. The policy also does not address reporting to the Plan, or Plan responsibility for oversight of TPMG review, determination or handling of identified over- or under-utilization.

With respect to monitoring under- and over-utilization of pharmacy, the policy states the Plan “manages pharmacy utilization by way of the Prescription Drug Formulary, including the provision of guidelines, and restrictions.” The policy notes that TPMG physicians may prescribe non-formulary drugs without authorization by using an exception code for approval. The “drug formulary guidelines and restrictions are used to help promote quality and appropriate prescribing by TPMG physicians.” The TPMG Regional and Medical Center Pharmacy and Pharmacy and Therapeutics (P&T)

Committee, which approves and publishes the formulary guidelines, is also responsible for evaluating utilization and monitoring adherence to the published guidelines. The policy, however, does not describe how or when P&T monitoring or evaluation are performed, what actions might be taken, how data are reported to the Plan or Plan responsibility for oversight of P&T review, determination or handling of identified over- or under-utilization.

The *UM/RM Program* addresses utilization monitoring only for the three types of services described above, albeit the description lacks specificity about frequency of monitoring, thresholds or triggers for action, or how the Plan handles findings of over- or under-utilization. Furthermore, there was nothing in the policy, or any other Plan policy, about monitoring over- and under-utilization for any other services. The *UM/RM Program* states on page 4: "... all practitioners and health professionals must be diligent in identifying any potential under-utilization of care or service," but, does not describe a method or processes for health professional identification of potential under-utilization, or how such information would be reported to the Plan, compiled, reviewed, analyzed or acted upon. The Plan did not furnish any evidence of such reports or data analysis.

For Southern California, the Plan's *Utilization Management Program Description (2018)* states on page 19: "Identification of quality, safety and risk incidents, patterns and trends through UM clinical review are escalated to the appropriate quality department in a timely manner. Results of monitoring and analysis of utilization of care and services, including over- and underutilization trends, are integrated into the [Plan's] Quality Program through reports to the Program's Quality Committees." The policy included no other description of the mechanisms for how the Plan monitors utilization of services, collects utilization data for, or responds to identified patterns over- or under-utilization.

The Plan did not provide the Department with data or reports regarding its monitoring or results of over and under-utilization review. In interviews, the Plan's UM staff stated there was no formal process for monitoring of over/under utilization. Plan physicians indicated that within the Plan's electronic system used to make referrals, called Health Connect, there is a prompt to cue the requesting provider regarding utilization, but this data is not specifically tracked. Plan staff stated health care services requiring prior UM authorization are limited to a specific, short list of services. For the most part, Plan providers decide what care to provide. The Plan was unable to demonstrate it monitors or tracks over- and under-utilization for health care services, whether or not the services require prior authorization.

**Plan's Compliance Effort:** In response to this deficiency, the Plan asserted it routinely analyzes data to monitor over- and under-utilization of services, but recognized the Plan can further enhance its program descriptions and committee meeting minutes to more accurately reflect the Plan's processes. The Plan anticipates the revised Program Description will be approved by the Northern California Regional Quality Oversight Committee during Q3 2020. The Plan also noted none of the cited deficiency Rules "use the specific verbiage 'over and under-utilization.'" The Plan disagreed it failed to furnish reports or data demonstrating the Plan adequately monitors utilization because the Plan "submitted materials demonstrate [*sic*] that the Plan has a robust infrastructure to achieve quality outcomes, and that utilization is systematically reviewed both at the



medical center level, and at the regional level.” The Plan’s response explained in detail the oversight provided in both the Northern and Southern California Regions.

### Northern California Region

The Plan stated the Program Description would be enhanced to outline the mechanisms used by the Plan to monitor utilization. The Plan proposed to modify the Program Description to describe oversight provided at the medical center level and Regional level. The Plan explained at the medical center level, utilization is monitored using its Crossing the Quality Chasm Dashboard that shows progress toward achieving targets such as HEDIS measures. The Plan provided a document to demonstrate use of this Dashboard. The provided document was a compilation of “some examples of how the committee oversees HEDIS measures to effectively improve performance and quality outcome.” The examples were comprised of five entries in a table, two for dates in 2017 and three for dates in 2018. The entries included QOC comments pertaining to specific medical centers. In one comment, the “QOC suggested the [medical center] work with accountable population managers (APM) and Pharmacy for oversight and alignment to improve diabetes performance.” The example showed the metric for diabetic testing performance increased slightly over the 2017 year. In another of the five entries, the QOC requested a specific medical center “share their infrastructure and collaborative work during an upcoming joint Area Manager/Physician-in-Chief meeting.”

At the Regional level, the Plan explained the QOC and subcommittees monitor medical centers and regional departments and programs, relying in many instances on metrics such as HEDIS scores. The QOC also reviews reports from its subcommittees and from programs such as lab, pharmacy, home health, hospice, and skilled nursing. The Plan provided sample QOC meeting minutes to demonstrate oversight. In the November 8, 2017 example QOC Meeting Minutes, the discussion notes stated the QOC received the Crossing the Quality Chasm report, certain medical center profiles and complaint summaries. The minutes also discussed concern about achieving certain metrics pertaining to outcomes of depression, as well as mental health access issues and hiring of therapists, stroke treatment timeframes, efforts to encourage cancer screenings and other programs. The September 25, 2018 Resource Management Committee Meeting Minutes Included notes about a presentation from the Imaging Appropriateness Committee whose purpose is to “make sure the appropriate imaging is given the first time, every time.” The notes included updates on HEDIS measures pertaining to imaging, including circumstances and strategies to decrease use of MRIs and CT scans.

### Southern California Region

The Plan explained its SCQC assures utilization monitoring. Medical centers are responsible to oversee quality assessment and performance. Medical centers report their performance on “Clinical Strategic Goal indicators” that include HEDIS measures and “other publicly reported measures.” Medical center reports show points and the percentage or rate of performance for each measure, change in performance and other benchmarks for each measure, along with the medical center’s target for each metric. The Plan provided an example of a Clinical Strategic Goal Dashboard.

The example Clinical Strategic Goal Dashboard listed “Results through April 30, 2020” included more than 200 specific HEDIS measures. The first 49 measures included prevention and screening measures such as breast cancer screening, tobacco quit rates, childhood and adolescent immunizations. Other sets of measures included, among others:

- 17 respiratory measures (such as appropriate asthma medication ratios in children and use of corticosteroids to treat chronic obstructive pulmonary disease),
- 18 cardiac condition measures (such as medication adherence and controlling high blood pressure),
- 28 diabetes measures (such as HbA1C<sup>17</sup> control and medication adherence) and
- 26 behavioral health measures (such as antidepressant medication management and follow up appointments following hospitalization or emergency room services).

The Dashboard included a column labeled “Quality Composite” which, for each of the more than 200 measures, either was marked with a “C” or was blank. The “Notes” column was either blank or was marked with a number, such as 1 or 4, but no legend for these note numbers was included.

The Plan also described its Appropriateness Committees that recommend appropriate utilization of services to optimize patient care. The Plan stated it has Appropriateness Committees for imaging, laboratory testing, medication, molecular pathology, product utilization, and procedure outcomes strategy. As an example of the effectiveness of Appropriateness Committee monitoring, the Plan provided SCQC meeting minutes. The provided March 23, 2018 SCQC minutes included a discussion on the Medication Treatment Appropriateness Committee, reporting an average score encompassing all 12 initiatives during Q1 2017 that included elder care, chronic pain, non-formulary prescribing and others. The minutes also reflected a discussion of opportunities to “[r]educe the combination use of sedative drugs ... with opiates to decrease risk of overdose” and strategies including “site visits by lead members to both high performing medical centers and those challenged with various initiatives to spread best practices, share solutions to obstacles, and develop leadership to drive results.”

Another SCQC subcommittee is the Utilization Management Steering Committee (UMSC) that oversees UM activities. The Plan provided the UMSC charter to show responsibility for reviewing under- and over-utilization, its UM Program Description and SCQC minutes “reflecting Health Plan Physician Advisors reporting to the SCQC on the review of Appropriateness Committees which monitors utilization....” The Plan provided SCQC meeting minutes to show reporting on review of the Appropriateness Committees.

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<sup>17</sup> HbA1C testing is a specific blood sugar test that shows the average blood sugar that attached to blood cells over the prior three-month period.

The highlighted portion of the SCQC March 23, 2018 meeting minutes stated, “Review of the meeting minutes for the various Utilization Action Team (UAT) meetings from September 2016 through February 2017” and “from March 2017 through August 2017.”

**Supporting Documentation:**

- Kaiser Foundation Health Plan, Inc. Northern California Region *2018 Utilization Management (UM)/Resource Management Program Description* (Quality Oversight Committee Approval Date: April 11, 2018)
- “Kaiser Permanente NCAL Region Performance Improvement” (undated) (showing examples of how the QOC oversees HEDIS measures)
- Quality Oversight Committee Minutes (Focused Version) (November 8, 2017)
- Quality Oversight Committee Northern California Region (August 2018, October 10, 2018)
- Resource Management Committee (RMC) Meeting Minutes (September 25, 2018)
- Example Clinical Strategic Goals Dashboard (April 30, 2020)
- SCQC Meeting Minutes (February 23, 2018)
- Plan document entitled “MedTAC Controlled Substances Initiative, 2013-Q-1 to 2020-Q1
- Kaiser Permanente Health Plan – SCAL Region Utilization Management Steering Committee (UMSC) A Sub Committee [sic] of Southern California Quality Committee 2018 Charter
- Utilization Management Program Description 2019: Kaiser Foundation health Plan Southern California Region

**Final Report Deficiency Status: Not Corrected**

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

The Department finds the Plan’s proposed corrective action, consisting solely of updating its Program Description, is not reasonably calculated to correct this deficiency. The proposed updates will apparently include descriptions of the Plan’s current practices, which the Plan described at length and which the Department assessed and determined to be insufficient. Rules 1300.70(a)(3) and 1300.70(c) require plans’ quality assurance systems to continuously monitor utilization of services to ensure they meet professionally recognized standards of practice. Utilization that fails to meet professionally recognized standards of practice may result in either overutilization of services (e.g., over prescribing, ordering unnecessary procedures or treating when not medically necessary) or underutilization (e.g., failing to prescribe, denying procedures or not providing treatment when the covered service is medically necessary). Monitoring for over- and under-utilization helps plans ensure all services are readily available at reasonable times and referrals to other providers are consistent with good professional practice (see Sections 1367(d), (e)(1)).

The Plan’s response included no substantive corrective action and failed to address issues raised in the deficiency, such as how or when monitoring for under- and over-utilization is performed. The Plan did not address statements made during onsite

interviews that the Plan has “no formal process for monitoring of over/under utilization” or that data in the Health Connect system concerning utilization is not tracked. The Plan’s response largely focused on use of aggregate outcome metrics such as HEDIS or special initiative targets.

The Plan’s medical center activities, including Crossing the Quality Chasm Dashboard and Clinical Strategic Goal Dashboard did not evidence data collection, analysis or reporting of under- or over-utilized services. The table provided by the Northern Region showing “some examples of how the committee oversees HEDIS measures to effectively improve performance and quality outcome” included brief suggestions about collaboration “to improve diabetes performance” and a comment that a medical center share its “infrastructure and collaborative work.” These comments did not relate to the utilization of any service, rate of utilization or identification of data suggesting under or over-utilization. Diabetes is a condition, not a service that is provided or utilized. Similarly, the example Clinical Strategic Goal dashboard listed HEDIS metrics, not analysis of utilization of services. For example, medication adherence, asthma medication ratios, immunization rates and controlling high blood pressure involve goals of care, not services provided or utilized. This Dashboard also included very little information beyond the metric itself.

With respect to Regional level oversight, the Plan’s explanations, examples and documents pertaining to activities of the QOC and SQOC committees and other subcommittees also addressed HEDIS metrics, outcome goals and strategies for use or limitation of services, but not any actual utilization data review or analysis. For example, the QOC’s discussion about mental health access issues and hiring of therapists is not an assessment of therapist utilization. Utilization monitoring involves, for example, assessment of use data to determine whether mental health services and medications are being over- or under-referred, over- or under- prescribed, or referred and prescribed appropriately based on documented need and use.

Similarly, a discussion about reducing use of sedatives combined with opiates to reduce overdose is an outcome driven initiative rather than a data gathering and analysis activity. While outcome driven initiatives are important, they are not the same as monitoring for under- and over-utilization. The UMSC 2018 Charter included a section titled “Responsibilities and Scope of Activities” and stated:

UMSC conducts ongoing monitoring to identify potential UM practices within the KP delivery system to oversee the structure of the UM Program and to identify potential quality issues, including:

Integration of UM into the KFHP Quality Improvement Program to ensure the effectiveness of the Utilization Management Program and to monitor compliance with established UM processes to include ...

- Review for potential over-under [*sic*] utilization of services

The UMSC 2018 Charter does not include specific information about utilization oversight, merely that there should be compliance monitoring with established UM

processes. The UM processes pertaining to utilization oversight in the UM Program Description states, in part,

Identification of quality, safety and risk incidents, patters and trends through UM clinical review are escalated to the appropriate quality department in a timely manner. Results of monitoring and analysis of utilization care and services, including over- and under-utilization trends, are integrated into the KFHP Quality Program through reports to the Program's Quality Committees. Activities related to the KFHP UM Program are reported to SCQC.

However, Department review of Quality Committee meeting minutes, as explained above, resulted in no evidence demonstrating monitoring, data gathering or analysis of utilization of services beyond outcome targets and strategies.

Accordingly, the Department finds the deficiency is not corrected and the Plan's proposed corrective action does not address all components of this deficiency.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a corrective action plan that addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of relevant policies and procedures, committee meeting minutes and related documents (including, but not limited to, minutes and associated documents pertaining to meetings of the QOC, SCQC, Appropriateness Committees USMC and Steering Committee), as well as any other documents or demonstrations deemed relevant, in addition to interviews with Plan staff.

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**Deficiency #6:      The Plan failed to demonstrate it complies with post-stabilization care requirements. (Northern California)**

**Statutory/Regulatory References:** Sections 1262.8(f)(1), 1371.4(b), 1371.4 (d), 1371.4 (j)(1), 1371.4 (j)(3), 1371.4 (j)(2)(B), (C), 1386(b)(1) and Rules 1300.71.4(a), (b)(1) to (3), (d).

**Assessment:** Sections 1371.4, 1262.8 and Rule 1300.71.4 describe requirements for health plan processes pertaining to post-stabilization care. Section 1371.4(j)(5) defines post-stabilization care as "medically necessary care provided after an emergency medical condition has been stabilized." The Department interviewed Plan staff, reviewed Plan policies and procedures and assessed post-stabilization denial files, for both the Northern and Southern California regions. The Department reached the following determinations with respect to the Plan's Northern California operations:

- The Plan failed to document all required information pertaining to post-stabilization care;
- The Plan failed to demonstrate it covers post-stabilization services when the Plan's response to requests is not timely;

- The Plan failed to send denial letters to enrollees when the Plan denied post-stabilization care services;
- The Plan denied emergency services as non-authorized post-stabilization care; and
- The Plan's policies and procedures do not require the Plan to cover post-stabilization care services in accordance with Rule 1300.71.4(b).

Each of these items is addressed below.

**a. *The Plan failed to document all required information pertaining to post-stabilization care. (Northern California)***

The Plan's policy #2.4, *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility (Authorization for PSC policy)* includes on page three, a list of information for which the Plan requires documentation with respect to post-stabilization care. This Northern California Plan policy requires the Plan to document the following:

**DOCUMENTATION**

- Date and time of the post-stabilization request in case notes
- Name of the requesting provider-name, title, specialty, location, phone number in case notes
- Discussions with the KP Medical Group Physician and determination of request documented in Decision Module of RENO case
- All non-Plan physicians involved in the case added into the Physician screen (treating, consulting, and weekend on-call) with phone number
- Procedures are entered in to the Clinical Documentation Module for all procedures performed on the enrollee with date, and authorization status
- How, when and to whom the authorization was communicated to at the non-Plan facility are to be documented in case notes
- Issuance of Provider Non-Authorization for Post Stabilization Care denial letter documentation per policy when appropriate

In addition, the Plan's *Utilization Management Denial of Practitioner Requested Services (UM Denial policy)* includes procedures pertaining to post-stabilization care in a non-Plan facility, describing requirements for documenting stabilization prior to transfer to a Plan facility. On page 13, the policy states:

**5.13.1 Outside Services Case Management**

**5.13.1.1** For Members in a non-Plan facility, when the treating non-Plan provider and a Plan provider clinically have determined the Member is stable to be transferred to a Plan facility, licensed designated staff will offer such transfer at KFHP's discretion, when there is an accepting KP Plan Provider and an appropriate KP bed available. If the Member elects to remain in the non-Plan facility, designated staff will issue the appropriate denial notice.

**5.13.1.2** The agreement between the providers that the patient is clinically stable to transfer must be documented in KP's internal record.

Section 1371.4 describes post-stabilization care requirements. Rule 1300.71.4 describes post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. Rule 1300.71.4(d) states "all requests for authorizations, and all responses to such requests for authorizations ... shall be fully documented.... Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request."

The Department reviewed 51 post-stabilization UM denial files.<sup>18</sup> The Plan provided revised files to the Department subsequent to the onsite portion of the survey to more clearly identify relevant information. The revised files had key items highlighted to identify information such as date and time the facility notified the Plan and other information.

All 51 files included a highlighted "Notification Date" to identify the date and time the non-Plan facility contacted the Plan to notify the Plan of the enrollee's presence at the non-Plan facility. This notification often occurred before the enrollee's condition was stabilized, as evidenced by clinical notes and the selection of a "No" indicator that asked whether "Provider Stated Stable for Transfer." The files frequently lacked a clearly documented request for authorization of post-stabilization care or the name of the person making a request. While files often included several documented conversations between the Plan personnel and personnel of the non-Plan facility, there was no consistent method to document information required by Rule 1300.71.4(d) or required by the Plan's *Authorization for PSC* policy. The files also included redacted information and the Department was not able to confirm that the Plan fully documents the name of the Plan person who received and responded to the request for authorization, as set forth in the Plan's policy.

The Plan faxed its denial notifications to provider facilities, informing them of the Plan's denial of coverage for post-stabilization care. The faxes were addressed to the facility, not to an individual and were signed "Northern California Outside Utilization Review Services" rather than by a named Plan representative responding to the request. Rule 1300.71.4(d) provides a list of minimum information to be documented and the Plan's *UM Denial* policy requires documentation in case notes of "how, when and to whom the authorization was communicated to the non-Plan facility." The Plan failed to comply with these requirements.

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<sup>18</sup> File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #51; and File #52.

Furthermore, of the 51 revised files, 45 files<sup>19</sup> lacked documentation of a peer-to-peer conversation or of any agreement between the Plan and the non-Plan provider regarding the enrollee's stability for transfer and plan for post-stabilization care, as required by the Plan's *UM Denial* policy. Section 1386(b)(1) states that grounds for disciplinary action by the Department against a health plan exist where "[t]he plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan...." A health plan's UM policy is required to be filed with the Department pursuant to Section 1351. By not documenting post-stabilization requirements as described in the Plan's UM policy, the Plan is operating at variance with the policy in violation of Section 1386(b)(1).

The following case examples demonstrate the Plan's lack of documentation:

- **Northern California MS File #3:** On July 4, 2018, the enrollee received emergency room services following a motor vehicle accident and was admitted the same day to the non-Plan hospital. The Plan documented it received notification from the facility on July 4, 2018, but because of redactions, the Department was not able to determine whether the Plan documented the name of the Plan representative who received the request. The Plan's response was faxed to the non-Plan medical center on July 10, 2018, but the response did not include the name of the person notified or the time the notification was sent. Further, the denial letter was signed: "Northern California Outside Utilization Review Services" rather than including the name of a Plan representative. There was also no documented agreement between Plan and treating provider of the enrollee's stability.
- **Northern California MS File #30:** On April 28, 2018, the enrollee received emergency room services following a high-speed motorcycle accident and was admitted the same day to the non-Plan hospital. The enrollee initially had critical lab values and on April 30 underwent surgery to correct a severe arm fracture. The Plan documented the facility contacted the Plan about the enrollee on May 1, 2018 at 10:48 a.m., but did not document the name of the provider making the request. Because of redactions, the Department was not able to determine whether the Plan documented the name of the Plan representative who received the request. The Plan documented the "patient had surgery yesterday, awaiting Attending to make rounds, possibly [to discharge] home today" but did not document agreement between the providers that the patient was clinically stable. In fact, the Plan physician notes stated: "Surgery must be done in the system" indicating that the Plan physician made a unilateral determination that surgery should have been done at a Plan facility, concluding the enrollee should have been transferred sooner.

The Plan's response, faxed to the facility on May 1, 2018 at 2:36 p.m., was a denial based on a determination that "services appear to have been provided post-stabilization

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<sup>19</sup> File #2; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #38; File #39; File #40; File #41; File #42; File #44; File #45; File #46; File #47; File #49; File #51; and File #52.



and Kaiser Foundation Health Plan was not contacted to obtain authorization as is required by law.” The denial letter was signed: “Northern California Outside Utilization Review Services” rather than including the name of a Plan representative.

***b. The Plan failed to demonstrate it correctly covers post-stabilization services as required.***

The Plan’s policy, *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility (Authorization for PSC policy)* states the Plan will respond to requests for authorization of post-stabilization care within 30 minutes of receiving the request, and “[i]f no definitive response is made within the 30-minute window, all post-stabilization care up to the point when a definitive response is given to the non-Plan facility is deemed authorized.” Furthermore, the policy states when the Plan does not authorize post-stabilization care, “appropriate arrangements will be made to transfer the enrollee in-Plan as soon as possible or to facilitate the post-stabilization care in-Plan post discharge. [The Plan] is responsible for the cost of all post-stabilization care needed to maintain the enrollee’s stabilized condition until the transfer in-Plan takes place.”

Non-contracting hospitals are required, prior to providing post-stabilization care, to seek to obtain the name and contact information of the patient’s health care service plan and contact the plan (or contracting medical provider), for authorization to provide post-stabilization care.<sup>20</sup> When a plan is contacted by a hospital for authorization to provide post-stabilization care, the plan must respond within 30 minutes of the initial contact, to either authorize the care or inform the hospital it will arrange for the prompt transfer of the enrollee to another hospital.<sup>21</sup> The following are two scenarios in which plans are required to reimburse the provider for post-stabilization care:

(a) the plan does not respond to the provider within the 30-minute time frame,<sup>22</sup>

(b) there is an unreasonable delay in transferring the enrollee, and the treating provider determined the enrollee required post-stabilization care.<sup>23</sup>

A plan may deny payment for post-stabilization care if the plan notifies the provider prior to or during the care, but in such a case, and in the two scenarios described above, the plan must pay for all care necessary to maintain the enrollee’s stabilized condition up to the time the plan effectuates the transfer, or the enrollee is discharged.<sup>24</sup> Specifically, Rule 1300.71.4(b)(2) states plans shall have authority to disapprove payment for medically necessary post-stabilization care, or the continuation of the delivery of such care, provided the plan notifies the provider prior to the commencement of the care or during the continuation of the care (in which case, the plan is not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider). However, Rule 1300.71.4(b)(3) states that notwithstanding subdivision (b)(2), plans must pay for all medically necessary health care provided to the enrollee necessary to maintain the enrollee’s stabilized condition up to the time the plan effectuates the

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<sup>20</sup> Sections 1262.8(b)(1) and (b)(2).

<sup>21</sup> Section 1371.4(j)(1), Rule 1300.71.4(b)(1).

<sup>22</sup> Section 1371.4(j)(2)(B); Rule 1300.71.4(b)(1), (2).

<sup>23</sup> Section 1371.4(j)(2)(C).

<sup>24</sup> Rule 1300.71.4(b)(2), (3).

enrollee's transfer or the enrollee is discharged.

Moreover, if a plan disagrees with the provider about the need for post-stabilization care, the plan must assume responsibility for the care of the enrollee by either taking over the care or by transferring the enrollee. If the plan fails to do so, care is deemed authorized and payment may not be denied.<sup>25</sup>

The Department reviewed 51<sup>26</sup> post-stabilization UM denial files provided by the Plan. In all 51 cases, the Plan's documented response to providers' notification was not timely, taking more than 30 minutes, yet the Plan did not cover post-stabilization care until the enrollee was discharged or transferred. The Plan simply sent denial notifications to the providers, typically based on one of two determinations.

One of the bases for denial was the Plan's unilateral determination that the enrollee was stable prior to notification. However, Section 1317.1(j) makes clear that the determination of stabilization is to be made in the opinion of the "treating physician and surgeon, or other appropriately licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon." Plan denials based on a determination that stabilization occurred prior to notification from the facility did not include documentation evidencing the determination was made in the opinion of a treating provider, consistent with Section 1317.1(j) and Rule 1300.71.4(b).

A second basis for denial was the Plan's determination that the non-Plan facility failed to contact the Plan as required, often despite the fact that the file included one or more communications between the Plan and the facility personnel. Section 1371.4(j)(3) states plans shall not require non-contracting hospitals to make more than one telephone call to the Plan. File review revealed the Plan often required hospitals to make more than one call. The following case files demonstrate the Plan's failure to appropriately cover post-stabilization services.

- **Northern California MS File #23:** An enrollee with diverticulitis experiencing worsening left sided pain sought treatment at a non-Plan emergency room on February 28, 2018, and was later admitted. Although the Department was unable to review the extent of care provided by the facility,<sup>27</sup> the enrollee underwent surgery on March 6, 2018. The facility contacted the Plan about the enrollee on March 7, 2018 at 4:51 p.m. On the same date at 7:50 p.m., the Plan documented that a Plan physician reviewer wanted to consult with Plan surgeons "before making a final decision" and noted the patient was not stable for repatriation because it was only two days post-surgery and the enrollee had an epidural line for pain medication.

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<sup>25</sup> Section 1371.4(d).

<sup>26</sup> File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #51; and File #52.

<sup>27</sup> The case file the Plan provided to the Department included only four of nine pages of hospital medical records.

On March 8, 2018 at 3:00 p.m., the Plan documented the facility's case manager stated the enrollee was stable for transfer, but the enrollee did not want to transfer to Kaiser because the enrollee had secondary health coverage and preferred to stay at the non-Plan facility. On March 8 at 4:29 p.m., the Plan sent a faxed denial to the facility denying "Inpatient care as of 03/01/2018, and any dates forward" based on the Plan's determination that "services appear to have been provided post-stabilization and Kaiser Foundation Health Plan was not contacted to obtain authorization as required by law."

In this case, the Plan's documentation demonstrated as of March 7, the Plan deemed the enrollee not stable for transfer, but the facility determined the enrollee was stable as of March 8. The file lacked any indication the treating provider deemed the enrollee stable as of March 1 or prior to admission. Section 1262.8(f)(1) requires plans to cover services until the time the enrollee (or guardian or spouse) refuses transfer. The Plan's failure to cover services to March 8, 2018, 3:00 p.m. violated the Plan's *UM Denial* policy and Section 1262.8(f).

- **Northern California MS File #37:** On August 16, 2018, the enrollee received emergency services and was admitted to a non-Plan hospital following a severe stroke. The facility initially contacted the Plan on August 16, 2018 at 9:14 a.m., although the enrollee was not stable at that time. At 10:26 a.m. on August 16, the Plan documented in its notes:

ADMIT AUTH: YES Admission is authorized for the treatment and stabilization of the above-mentioned issues until 10 AM the next morning, August 17, 2018, when stability for transfer should be reevaluated. No post stabilization tests or treatments are authorized and will require separate authorization. When stable, patient may be transferred to Kaiser for further care.

This documentation shows the Plan apparently authorized emergency services, which do not require authorization, and for which plans may not require or apply time-limited authorizations. Section 1371.4(b) states plans must "reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee" and does not contemplate time-limited, serial authorizations.

The Plan's internal case notes also stated the Plan declined to authorize post-stabilization care, although the file does not indicate whether, when or to whom at the facility the Plan communicated this determination.

On August 17 and August 18, 2018, the Plan documented clinical updates, noting the enrollee's condition was still not stable for transfer. Documentation also indicated there had been no communication between a Plan physician and the treating provider. The next Plan entry in the internal case file occurred on August 21, stating in part: "Case discussed with [Plan physician]. Denial letter to be sent due to insufficient communication. MD would like to discuss case with treating MD to determine stability for transfer/pick up images."

Thus, the Plan intended to deny coverage based on what it deemed “insufficient” communication from the facility prior to ascertaining whether the enrollee was even stable for transfer. The Plan may not deny services during a time that might involve continued care to stabilize the enrollee’s condition and the Knox-Keene Act does not contemplate denial of post-stabilization services, several days following notification by the non-Plan facility, for “insufficient communication.” Section 1371.4(j)(3) states plans “shall not require a hospital representative or a non-contracting physician and surgeon to make more than one telephone call....” Thus, under the law, one phone call is sufficient communication.

According to Section 1371.4(d), “[i]f there is disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient....” In this case, at any time the Plan disagreed with the facility, the Plan was obligated to assume care (or make arrangements to transfer following stabilization). Once contacted by the facility, the onus was on the Plan to initiate and follow up any communications deemed necessary by the Plan and to make arrangements to provide care or transfer the enrollee if the Plan did not want to authorize the facility to provide post-stabilization care.

Between September 1 and September 3, 2018, the Plan documented unsuccessful attempts to obtain copies of the enrollee’s radiology images, noting the Plan required “neuro clearance” and noting “we cannot repa[riate] without images available for review.” Thus, as of September 3, 2018, the Plan concluded it could not yet transfer the enrollee, yet on September 4, 2018, the Plan documented that enrollee “has been stable for repa[riation] since 8/30/2018.” Another entry on the same date stated: “Barrier to repa[riate] this case is due to the late hour. The CD [containing the needed radiology images] was finally uploaded and available late afternoon today. Multiple attempts to get clearance was to no avail.” On September 5, 2018, a Plan physician reviewed the images and determined the enrollee “is appropriate for transfer to home facility” and the enrollee was transferred to a Plan facility the same date. Thus, in this case, there was delay in the Plan transferring the enrollee, and pursuant to Section 1371.4(j)(2)(C), the Plan was obligated to pay for care during this period.

Notwithstanding the foregoing, on August 31, 2018 at 10:59 a.m., five days before the Plan effectuated the enrollee’s transfer, the Plan sent a fax to the facility which stated in part:

You have requested that we authorize the following care for: Acute care services. We have reviewed the care our member received after you contacted us. After reviewing the medical information you provided we have denied authorization for care or services provided because the services appear to have been provided post-stabilization and Kaiser Foundation Health Plan was not contacted to obtain authorization as is required by law. The following requested services are not authorized: Any acute care services care [sic] as of 08/23/2018. Repatriation offered on 08/31/2018.

According to Rule 1300.71.4(b)(2) and (3), a plan may disapprove payment for post-stabilization care provided it notifies the provider either prior to or during the provision of

care, but the plan must pay for all medically necessary care “to maintain the enrollee’s stabilized condition up to the time the health care service plan effectuates the enrollee’s transfer or the enrollee is discharged.” The Plan failed to comply with this requirement.

Once a plan makes a determination to not authorize post-stabilization care and elects to transfer the enrollee, as the Plan did in this case, it was the Plan’s obligation to promptly transfer the enrollee following stabilization. The Plan was obligated to pay for care during the delay caused by the Plan’s unsuccessful attempts to obtain radiology images and pay for care until September 5, 2018, when the Plan effectuated transfer of the enrollee following stabilization and following days of delay.

- **Northern California MS File #12:** On the morning of May 11, 2018, the enrollee went to a non-Plan emergency room complaining of right-side abdominal pain and extreme tenderness over the area of the gall bladder. The hospital admitted her at some point.<sup>28</sup> While at the non-Plan facility, blood work was done and a CT scan performed to assess for gallstones. The Plan’s internal case notes, including clinical information about the enrollee, appeared to be copied from the facility’s submitted medical records, but did not record any communication with the facility. The Plan documented May 12, 2018 at 2:12 p.m. as the date and time the facility notified the Plan of the enrollee’s presence at the facility. At 4:02 p.m. on the same date, the Plan’s physician documented review of the clinical notes and determined the enrollee “was stable at the time of evaluation in the ED [and] will do post stability denial as we could have transferred her from the ED.”

There was no documentation indicating the treating provider was of the opinion the enrollee was stable for transfer at that time, in accordance with Section 1317.1(j). Furthermore, the Plan’s denials indicate the Plan erroneously takes the position that the critical point of communication from the non-Plan facility is prior to, or at the first moment of stabilization. The law makes clear that non-Plan facilities may contact plans for authorization *following* stabilization. Specifically, Rule 1300.71.4(b) specifies the contact and response time requirements commence “when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and cannot be safely discharged....” Section 1262.8(b) requires the facility to contact the health plan prior to providing post-stabilization care, defining stabilization (per Section 1317.1) as occurring when the treating physician believes “no material deterioration of the patient’s condition is likely to result from, or occur during, the release or transfer of the patient.” These two provisions make clear that the critical point of stabilization is not at the time the enrollee achieves clinical stability at the facility, but at the time the treating provider determines there is risk to stabilization by transferring or discharging the enrollee.

In this case, the Plan’s response to the facility by fax on May 12 at 5:49 p.m., denied care “from the time of admission 05/11/2018 and forward.” According to Rule 1300.71.4(b)(2) and (3), the Plan was obligated to first notify the treating provider of its decision and pay for care to the point the Plan effectuated the transfer or until

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<sup>28</sup> The case file the Plan submitted to the Department included medical records that commenced on page 7 of 21, and also omitted pages 8 and 17 through 21, so it is not clear what time the enrollee was admitted.

discharge. Furthermore, a health plan cannot unilaterally and retrospectively determine when stabilization occurred based on review of medical records, having the benefit of hindsight and in the absence of the treating provider's opinion.

- **Northern California MS File #41:** An enrollee with congestive heart failure experienced shortness of breath and sought care from a non-Plan emergency room. He was admitted to the hospital on August 16, 2017, where labs were performed, a CT scan was done and he had a cardiology consult. Plan documentation indicated the facility contacted the Plan the morning of August 18, 2017, although the name of the contacting person is not documented, nor was the name of the Plan representative who received the notification. The file also lacks documentation that the treating provider determined the enrollee was stable prior to the notification. The Plan's internal notes do not include any documented review by a Plan physician although the case notes indicate a Plan physician made the determination to deny post-stabilization care. On August 18, 2017 at 4:01 p.m., the Plan notified the facility by fax that it was denying "Inpatient care beginning on August 16, 2017 and forward" because "services appear to have been provided post-stabilization and Kaiser Foundation Health Plan was not contacted to obtain authorization as is required by law."

Contrary to the reasoning in the denial letter, the Plan's documentation demonstrates the facility did contact the Plan, on August 18, 2017. The file is bereft of anything suggesting the treating provider considered the enrollee stabilized to transfer prior to admission. In fact, the file included no clinical records from the treating facility at all, and the only documented attempt to obtain records was made on April 3, 2019, ostensibly in preparation for the Department's onsite survey of the Plan.

***c. The Plan failed to send denial letters to enrollees when the Plan denied post-stabilization care services, operating at variance with its filed policies and procedures.***

The Plan's policy, *Utilization Management Denial of Practitioner Requested Services*, requires the Plan to issue written notification to enrollees when the Plan denies, modifies or delays services. Specifically, the policy states under section 5.3 (Process for Issuing Denial Notices):

**5.3.1** Denial Notices will be issued whenever KFHP approves, denies, modifies, delays, discontinues or reduces a service or item requested by a physician because of benefit coverage, exclusion or exhaustion of benefits or lack of Medical Necessity.

**5.3.2** The member will be notified of their appeal rights in writing whenever denial notices are issued.

The Department reviewed 51<sup>29</sup> post-stabilization UM denial files. Although the Plan issued faxed denial letters to providers, none of the 51 files contained a denial letter

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<sup>29</sup> File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34;

addressed to enrollees. Because the Plan denied post-stabilization services based on either benefit coverage or medical necessity, the Plan's policy required the Plan to send denial letters and appeal rights to enrollees. The files demonstrated the Plan does not notify enrollees of denied services or appeal rights, contrary to the requirements of its *Utilization Management Denial of Practitioner Requested Services* policy.

Section 1386(b)(1) states that grounds for disciplinary action by the Department against a health plan exist where "[t]he plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan...." As explained above, a health plan's UM policy is required to be filed with the Department pursuant to Section 1351. By not sending denial letters to enrollees concerning denied post-stabilization care, the Plan is operating at variance with the policy in violation of Section 1386(b)(1).

**d. The Plan denied emergency services as non-authorized post-stabilization care.**

The Plan's policy, *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility*, states on page 1:

The Health Plan emergency benefit covers all medically necessary emergency care in a non-Plan facility until the enrollee is clinically stable as well as certain post-stabilization care provided within the treatment area of the emergency department that results in the completion of the enrollee's care and his/her release from the hospital. Services in an emergency room that do not result in the enrollee's release, the inpatient setting (general hospital, psychiatric hospital and acute rehabilitation hospital) and skilled nursing care in a SNF are covered under the post-stabilization benefit. All post-stabilization care, with the exception of certain care associated with a psychiatric emergency medical condition as described below, must be authorized by KP to be a covered Health Plan benefit, unless it was not reasonably possible for the enrollee to contact KP (such as the enrollee being unconscious or a young child without an adult or guardian).

Rule 1300.71.4(a) states:

Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.

The Department reviewed 51 post-stabilization UM denial files. The Department identified 11<sup>30</sup> cases where the documentation indicated coverage was improperly

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File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #51; and File #52.

<sup>30</sup> File #2; File #3; File #4; File #8; File #13; File #16; File #17; File #23; File #38; File #40; and File #51.

denied because some health care services were provided prior to the enrollee's stabilization.

### **Case Examples**

- **File #2:** The enrollee was admitted to a non-Plan facility on January 28, 2018 following emergency treatment for a heart attack. The facility contacted the Plan on January 31, 2018 at 11:49 a.m. The first clinical note documented by the Plan's case manager (CM) was dated January 31, 2018 at 5:30 PM, in which the CM documented the enrollee was stable for transfer. There was no documentation the treating provider determined the enrollee to be stable prior to January 31, 2018. The enrollee was to be discharged to a skilled nursing facility (SNF) on January 31, 2018; however, there was a documented barrier to discharge. A delay ensued due to the enrollee's need for a specific piece of medical equipment. The Plan denied care from January 29, 2018 forward, prior to the documented point of stabilization and prior to the Plan's delay in transferring the enrollee.
- **File #3:** The enrollee was admitted to a non-Plan facility on July 4, 2018 at 2:03 p.m. after receiving emergency services following a motor vehicle accident. The Plan was notified of the admission on July 4, 2018 at 3:09 p.m. On July 10 at 3:21 pm., the Plan documented it received notification from the facility that the enrollee was deemed stable for transfer, but by the following day the patient had destabilized. By July 12, Plan physicians were continuing to request additional clinical information before making a determination of whether to transfer the enrollee. The enrollee again destabilized, requiring additional procedures and by July 17 was still not able to be repatriated according to Plan documentation. On July 18, the Plan transferred the enrollee to a contracted facility.

On July 10, 2018 at 5:11 p.m., eight days before transferring the enrollee to a contracted facility, the Plan faxed a denial notice to the facility. The Plan denied "Any acute care services as of July 9, 2018; Repatriation offered on July 10, 2018" and further stated "the services appear to have been provided post-stabilization and Kaiser Foundation Health Plan was not contacted to obtain authorization as required by law." In fact, the Plan documented contact from the facility on July 4, 2018 and ongoing Plan documentation included "Daily Clinical Progress" notes and clinical updates suggesting the Plan was in contact with the facility on virtually a daily basis. The Plan's assertion that the provider failed to contact the Plan to obtain authorization is contrary to the Plan's own records. Furthermore, Plan notes clearly documented destabilization of the enrollee between July 11 and July 17 and thus, the Plan failed to cover services necessary to stabilize and maintain stabilization, in violation of the Plan's policy, Section 1371.4(b) and Rule 1300.71.4(a) which requires plans to pay for all medically necessary health care services "during periods of destabilization (after stabilization of an enrollee's emergency medical condition)."

- e. ***The Plan's policies and procedures do not require the Plan to cover post-stabilization care services in accordance with Rule 1300.71.4(b).***



The Department found the Plan's policies and procedures do not meet the requirements of Rule 1300.71.4(b). The Plan's policy, *Emergency Prospective Review Program (EPRP) Notification and Authorization Process*, states on pages 6-7:

5.1.6 When a request for authorization of Post-Stabilization Care is received for a patient in a non-Plan emergency department, EPRP promptly responds to these requests within 30 minutes from the time the request is received, whether the response is an authorization or a denial of the request. If no definitive response is made within the 30-minute window, all post-stabilization care up to the point when a definitive response is given to the Non-Plan Facility is deemed authorized. A Non-Plan Hospital is required to make only one telephone call to request authorization.

5.1.10 For Health Plan members for whom notification is received, either through the Notification Telephone Number or directly from the community provider, **after** the member has been admitted to a Non-Plan Facility, OURS in SCAL and Outside Case Management in NCAL promptly responds to these requests within 30 minutes from the time the request is received for care from that point forward, whether the response is an authorization or a denial of the request. OURS and Outside Case Management respond within 24 hours for care administered prior to the notification call. If no definitive response is made within the 30-minute window, all post-stabilization care up to the point when a definitive response is given to the Non-Plan Facility is deemed authorized. Non-Plan Hospital is required to make only one telephone call to request authorization. [Emphasis in original.]

Rule 1300.71.4(b) requires the following:

In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time

necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

(3) Notwithstanding the provisions of Subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

The Plan's policy states that when it does not provide a definitive response to a request for post-stabilization medical care within one half hour of receipt of the request, the Plan will cover payment for post-stabilization care only up to the point when it provides a definitive response to the non-Plan facility. The Plan's policy does not state it authorizes coverage for all medically necessary post-stabilization care if it fails to respond to the request within one half-hour of receipt of the request, as required by the Rule.

**TABLE 4**  
**Post-Stabilization File Review**

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Post-stabilization UM denial files	51	Documented peer-to-peer/agreement of stability for transfer	6 (12%)	45 (88%)
Post-stabilization UM denial files	51	Responses to post-stabilization requests exceeding 30 minutes shall be deemed authorized	0 (0%)	51 (100%)
Post-stabilization UM denial files	51	Plans shall cover medically necessary health care services prior to stabilization or during periods of destabilization	40 (78%)	11 (22%)

**Plan's Compliance Effort:** The Plan provided the following response to the components of this deficiency:

Failure to document all required information (Northern California Region)

The Plan acknowledged process gaps with respect to documentation and initiated corrective action to include revisions to the Northern California Outside Utilization Review Services Policy #2.4, *Authorization for Post Stabilization Care in a Non-Plan Acute Care Facility* (OURS policy), to ensure compliance with Section 1300.71.4(d). The Plan submitted a redlined version of the policy and anticipated leadership approval by July 31, 2020 with training on policy changes by August 15, 2020.

#### Failure to correctly cover post-stabilization services

The Plan acknowledged process gaps existed with respect to tracking the 30-minute response time frame and with documenting stability determinations. The Plan proposed the following corrective actions:

- Enhancing Northern California's RENO system with a software module used in the Southern California Region. The module enables staff to accurately track response time. The Plan anticipated the module would go into production by July 10, 2020, with staff training on the module to occur by July 20, 2020.
- Revisions to the Plan's *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility* policy to ensure it properly addresses scenarios in which the Plan is required to reimburse the provider for post-stabilization care. The Plan anticipated policy revisions to be approved by July 31, 2020, with staff training on the policy revisions to occur by August 15, 2020.

Notwithstanding the corrective action described above, the Plan noted that the 30-minute response time is triggered by a request for authorization to provide necessary post-stabilization medical care, and indicated sometimes the Plan receives calls prior to authorization notifying the Plan the enrollee is receiving emergency treatment. Second, the Plan stated it has a statutory right under Section 1262.8(b)(3) to seek relevant information before responding to a request for authorization. Section 1262.8(b)(3) states, in relevant part, that once a patient has been stabilized, the facility shall:

Upon request of the ... plan ... provide to the plan ... the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.

The Plan reasoned that Section 1262.8(b)(3) "would be rendered meaningless if a request for reasonably necessary information did not toll the time for responding. Third, the Plan's position is that plans must "pay for all care rendered between when the provider requests authorization and when the Plan belatedly responds."

Next, the Plan responded to the Department's reliance on Section 1317.1(j), which defines the term stabilized as a condition to be determined by the treating provider. The Plan acknowledged, "in general, deference must be afforded to the treating physician's opinion," but the Plan relied on an arbitration award decision<sup>31</sup> to specify "the standard for deference to the treating physician's decision as to stability is that the physician's

<sup>31</sup> *Prime Healthcare Cases*, 2019 WL 1987335 (Cal. Super. Feb. 11, 2019).  
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judgment should control when the physician is making reasonable, independent medical decisions....” The Plan asserted Section 1371.1(j) “must be read in concert with other code provisions that require physicians to form independent, reasonable medical judgments and that require providers to timely contact health plans to request authorization. Thus, the Plan concludes where a physician's decision is unreasonable, unsupported by the medical evidence, or in significant conflict with the standard of medical practice in the community, that decision is not entitled to deference. Based on this conclusion, the Plan stated plans have the ability to determine stability in cases of late notification when the provider did not timely identify the enrollee’s coverage with the Plan and did not carry out its obligation to request authorization before providing post-stabilization care. In cases of late notification, the Plan asserted it is entitled to review the medical record to determine what portion of the stay is emergent (and therefore covered) and what portion of the stay is post-stabilization (and therefore not covered).

#### Failure to send denial letters

The Plan acknowledged it did not send denial notices to enrollees and proposed the following corrective action, which the Plan anticipated to be completed by August 15, 2020:

- Staff training concerning policy requirements for sending denial letters to enrollees along with appeal rights.
- Revision to determination letter templates for post-stabilization decisions to include the name of the Plan physician making the determination, any necessary language changes and addition of a “cc to member” note in the footer of the letter.

#### Denial of emergency services as non-authorized post-stabilization care

The Plan stated it will review denied post-stabilization claims to ensure it did not deny emergency services that should have been covered. The Plan is also providing training to its staff on revisions to the OURS Policy #2.4 *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility*.

#### Plan policies do not require coverage of post-stabilization care services in accordance with Rule 1300.71.4(b)

The Plan stated its corrective action for this component of the deficiency includes enhancing Northern California’s RENO system with a software module used in the Southern California Region, as described above. The Plan will also revise its OURS Policy #2.4 *Authorization for Post-Stabilization Care in a Non-Plan Acute Facility* to ensure compliance with key elements of Rule 1300.71.4(b).

The Plan restated its position that the following policy language is compliant with Rule 1300.71.4(b): “If no definitive response is made within the 30-minute window, all post-stabilization care up to the point when a definitive response is given to the Non-Plan Facility is deemed authorized.” The Plan cited the following portion of Rule 1300.71(4)(b) as the basis for its position:

[T]he health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider....

Based on this portion of Rule 1300.71.4(b)(2), the Plan stated that missing the 30-minute deadline does not obligate the Plan to cover all inpatient days.

With respect to required readjudication of claims, the Plan stated since October 31, 2018, the Plan identified 383 case requiring retroactive review. The review will assess for compliance with the 30-minute response time, payments due providers and any enrollee overpayments. The Plan will also review to determine whether there is sufficient documentation to support the Plan's denial determinations. The Plan stated in cases where no physician judgement was made about stability due to late notification, the Plan will review medical records to ensure they support the Plan's stability determination. The Plan anticipates completing review of the 383 cases by September 20, 2020.

The Plan will audit 30 randomly selected post-stabilization files to audit the effectiveness of the corrective action during Q4 2020. The Plan submitted a template of the tool to be used for the audit.

**Supporting Documentation:**

- Utilization Management Denial of Practitioner Requested Services, Policy Number 17.0 (Approval Date August 5, 2019)
- Authorization for Post-Stabilization Care in a Non-Plan Acute Facility, Policy Number 2.4 (Last Revision Date: July 10, 2020)
- Template Claims Review Grid
- Validation Audit Tool for Deficiency 7

**Final Report Deficiency Status: Not Corrected**

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

The Plan initiated corrective action, which is ongoing. The Plan proposed to revise its Northern California OURS policy and provide training to ensure the Plan documents post-stabilization requests and response to requests as required by Rule 1300.71.4(d). Revisions to this policy will also address appropriate coverage of post-stabilization care required by Rule 1300.71.4(b). Concerning failure to send denial letters, the Plan is revising letter templates and providing staff training. The Department will need to conduct file review at the Follow-Up Survey to assess compliance with these requirements. With respect to failure to correctly cover post-stabilization services, the Plan requires additional time to implement the new software module and provide staff

training. The Department may review post-stabilization files and claims at the Follow-Up Survey.

The Department does not dispute the Plan's position that the 30-minute response time is triggered by a request for authorization to provide post-stabilization care and not by a call made simply to notify the Plan an enrollee is currently receiving emergency care. Also, Section 1262.8(b)(3) requires the non-contracting hospital, upon request by the plan, to provide "the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary" for the Plan to make a decision whether to authorize the request to provide post-stabilization care or to promptly transfer the enrollee. During interviews, the Plan stated if an enrollee is not stable for transfer, the Plan authorizes admission for the first 24 hours with ongoing evaluation for stability to permit transfer to an in-network facility. Therefore, it is the Plan's obligation to ensure when it receives a request for authorization, the Plan documents the information requested and the time of the request as well as the time the facility provided the responsive information. Further, the Plan must ensure that only information reasonably necessary to make the determination is requested. During the Follow-Up Survey, the Department will assess the Plan's documentation to determine whether it supports the Plan's 30-minute response time.

The Plan, however, is incorrect that in the event the Plan responds beyond the 30-minute time frame, coverage ends at the point "the Plan belatedly responds" to the request for authorization. The Plan relies on a portion of Rule 1300.71.4(b)(2) for its position. Rule 1300.71.4(b)(2) and (b)(3) state in their entirety as follows:

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

(3) Notwithstanding the provisions of subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

In asserting its position on the basis of Rule 1300.71.4(b), the Plan failed to consider the specific exception to the disapproval of payment as described in subdivision (b)(3). Rule 1300.71.4(b)(3) expressly states “[n]otwithstanding the provisions of Subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.” (emphasis added). Thus, when a plan notifies the non-contracting hospital of its intent to transfer the enrollee, the plan is obligated to pay for medically necessary post-stabilization care up to the point of transfer or discharge.

The Department also finds the Plan's reliance on the *Prime Healthcare Cases* is misplaced. Those cases involved a hospital's challenge to an arbitration award made in favor of the Plan, its medical groups and KFH (Kaiser Parties), and requested that the court vacate the Arbitration Panel's decision. Among the issues in dispute were denied payments by the Plan for post-stabilization services. In reviewing the law, the court first cited the Section 1317.1(j) definition of stabilization which is also cited by the Department in this Final Report. The court then stated it agreed with the Arbitration Panel that “the proper standard [is] one of deference to physician judgment when the physician is making reasonable, independent medical decisions.” The Kaiser Parties pointed out to the court that the Arbitration Panel did not give complete deference to the judgement of the hospital's physicians regarding stability decisions because “of corrupted stability determinations.” The court cited several of the hospital's improper and restrictive policies and practices that served to restrict the independence of physician judgment and compel physicians to use unreasonable bases to find patients not stable for transfer. Based on the Arbitration Panel's determination that the hospital imposed coercive means to restrain physicians from making independent medical decisions about patients' stability, the court found the Arbitration Panel did not err in disregarding the treating physicians' determinations of stability.

The Plan's response to the Preliminary Report cited the *Prime Healthcare Cases* decision for the proposition that “where a physician's decision is unreasonable, unsupported by the medical evidence, or in significant conflict with the standard of medical practice in the community, that decision is not entitled to deference.” First, the *Prime Healthcare Cases* decision is not law and only assessed whether the Arbitration Panel erred in its decisions. Second, the Kaiser Parties, including the Plan itself, acknowledged the Panel's lack of deference to the treating physician was based on “corrupted stability determinations” that impeded physicians' independent judgment. The Plan's attempt to equate corrupted determinations and lack of independent judgment with the Plan's own determinations that physician decisions are unreasonable, not supported by medical evidence, or in conflict with standards of practice, in the absence of coercive, corrupted practices such as those discussed in the *Prime Healthcare Cases*, is unfounded. The Plan did not identify any of the deficient cases cited by the Department as involving coerced or non-independent physician determinations. As the Plan pointed out, in receiving and handling post-stabilization requests from non-contracted hospitals, the Plan has the ability to request reasonably necessary information to make its decision. The Plan is therefore in a position to request information about stability and not simply, after the fact, rely on its own staff's failure to obtain the information as grounds for making its own stability determination.





- Revisions to its *Drug Formulary Processes Policy* for the Northern Region and the Southern Region (policies CAPHARM.8.1.2 and CAPHARM.8.1.2.2) to indicate the formulary available on the Plan's website to enrollees, non-contracted providers and the public, will be updated monthly.
- Update Member Guidebooks to reflect the monthly formulary update.

The Plan stated in Q4 2020, National Pharmacy Benefits will conduct an audit to assess the effectiveness of the corrective action. Additionally, the Drug Intelligence & Strategy department will audit the P&T Committee minutes during Q4 2020 for compliance.

**Supporting Documentation:**

- Screenshots showing May 2020 updates to Drug Formularies for Southern and Northern California Regions
- SCPMG Drug Formulary Processes, Policy Number CAPHARM.8.1.2 (Last Revision Date: July 1, 2019)
- TPMG Drug Formulary Processes, Policy Number CAPHARM.8.1.2.2 (Last Revision Date July 1, 2019)
- Plan document "Guidebook Excerpt"

**Final Report Deficiency Status: Not Corrected**

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

The Department finds the Plan has initiated corrective action that will take additional time to fully implement. At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of Plan formularies (including electronic versions), policies and procedures, P&T Committee meeting minutes and review the Plan's website. The Department will also conduct interviews with key staff.

## **SECTION II: SURVEY CONCLUSION**

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

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 Review of the Plan and issue a Report within 18 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web Portal, eFiling application. 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, **2019 Routine Full Service Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.

[Plan Response to the Final Report](#)