DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

ROUTINE MEDICAL SURVEY

FINAL REPORT

KAISER FOUNDATION HEALTH PLAN

ISSUED TO PLAN: OCTOBER 24, 2003
ISSUED TO PUBLIC FILE: NOVEMBER 3, 2003

Kaiser Foundation Health Plan
Final Report of Survey of Medical Plan
October 24, 2003

TABLE OF CONTENTS

I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a medical survey of each licensed health care service plan at least once every three years. The medical survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] A copy of this report will be sent to the Department's Office of Enforcement for review.

Generally, the survey reviews the major areas of utilization management, access and availability, grievances and appeals, quality management in the following specific categories:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits; and
- Overall performance of the plan in meeting the health needs of enrollees.

The Department regards a Plan's Grievance and Appeals system as a core mechanism that enrollees can use to exercise their rights if they need to resolve problems with their health plan. The Department requires plans to resolve all Grievances and Appeals in a professional and expeditious manner. This requirement is pursuant to the Knox-Keene Health Care Service Plan Act of 1975, beginning at Section 1368, and the corresponding regulations promulgated pursuant to the Act under Title 28 of the California Code of Regulations, beginning at Rule 1300.68.

The Department's continued efforts to ensure that enrollees have the ability to exercise their rights was demonstrated with the further additions to the Grievances and Appeals regulations which were enacted as of February 2003. The Department is vigorously enforcing these regulations to ensure that enrollees are able to obtain the services to which they are legally entitled.

This Final Report summarizes the findings of the Routine Medical Survey of Kaiser Foundation Health Plan, Inc. (the "Plan"). The Plan submitted pre-survey documentary information to the Department on October 28 and October 30, 2002 for the Plan's Southern California Region and the Northern California Region, respectively. The on-site review of the Plan's Southern Region was conducted from November 4 to 8, 2002, in Pasadena, California. The on-site review of the Plan's Northern Region was conducted from November 18 to 22, 2002, in Oakland, California.

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43. ("the Rules")].

Pursuant to Section 1380(h)(1) of the Act, the Department determined that additional time was required to fully and fairly report the survey results. Subsequent to the on-site review conducted in November 2002, the Department determined that it required additional information regarding the Plan's Member Services/Grievance process at the Medical Center level as well as how the Plan monitors the appropriateness and effectiveness of specialty care provided to enrollees. Section VI. of this Final Report describes the Department's findings related to these two issues.

As part of the survey process, the survey team conducted interviews and examined documents at the Plan 's administrative offices in Pasadena and Oakland, California. The names of the survey team members are listed in Appendix A. The names and titles of persons who were interviewed at the Plan are listed in Appendix B.

The Preliminary Report of the survey findings was sent to the Plan on July 28, 2003. All deficiencies cited in the Preliminary Report required follow up action by the Plan. In addition to requiring follow up actions, the Department may also take other actions in regards to violations, including enforcement actions. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted a timely response on September 15, 2003.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. **If the Plan wishes to append its response to the Final Report, please notify the Department before November 3, 2003.**

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after November 3, 2003. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. The final report to the public will be placed on the Department's website: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow up survey of the Plan within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

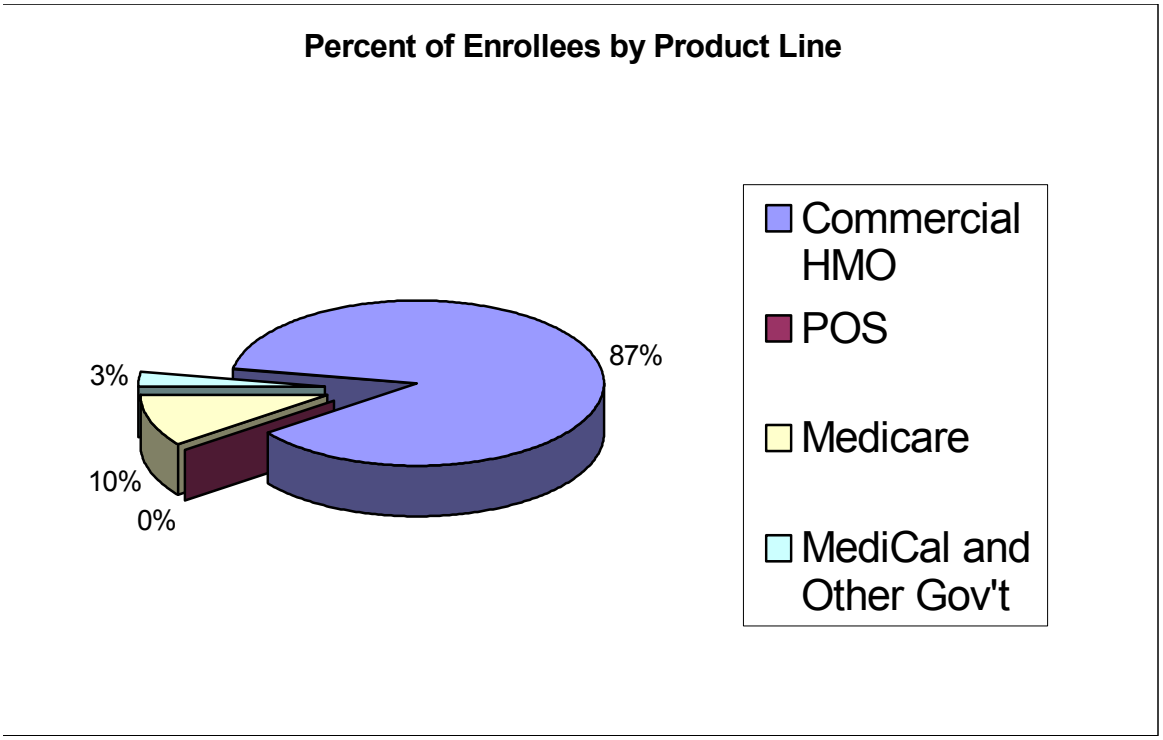
Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

II. ORGANIZATION AND HEALTHCARE DELIVERY SYSTEM

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire and other on-site materials:

Date Plan Licensed	November 4, 1977	
Type of Plan	Full service health care service plan	
For profit / Non-profit Status	Not-for-profit	
Service Area(s)	Statewide (see Appendix D)	
Number of Physicians	**Southern CA Region**	
	Primary Care Physicians	**Specialty Physicians**
	2,023 (includes contracted physicians)	3,533 (includes contracted physicians)
	Northern CA Region	
	Primary Care Physicians	**Specialty Physicians**
	3,114 (includes contracted physicians)	3,988 (includes contracted physicians)
Number of Affiliated Medical Groups or IPAs	2	

	Product Lines	Enrollees	
		Southern CA Region	Northern CA Region
Number of Enrollees as of August 2002	Commercial	2,725,704	2,751,696
	Medicare	295,386	350,614
	Medi-Cal and other government	93,020	83,452
	PPO/POS	5,054	1,234
	Total	**3,119,164**	**3,186,996**
	Total Plan Enrollment	**6,306,160**	



History and Organizational Structure

The Plan has been in existence since the 1930's as a prepaid, group-practice health care plan. The Plan defines "Kaiser Permanente" as Kaiser Foundation Health Plan, Inc. (the "Plan"), Kaiser Foundation Hospitals ("KFH"), and the Permanente Medical Group ("PMG"). Collectively, these three entities form an integrated health care system that provides and arranges for hospital, medical and other health care services for Plan enrollees.

The Plan is a non-profit California corporation that contracts with individuals and groups to provide or arrange prepaid health care benefits. The Plan contracts with KFH, also a non-profit California corporation, that owns and operates community hospitals, to provide or arrange hospital services for Plan members.

The Plan contracts on a mutually exclusive basis with the for-profit PMG for professional services. Permanente Medical Group is an independent physician organization with two entities operated independently and divided according to their geographic locations: the Permanente Medical Group ("TPMG") in Northern California and Southern California Permanente Medical Group ("SCPMG") in Southern California. While SCPMG operates as a multi-specialty physician partnership, TPMG is a multi-specialty professional physician corporation. TPMG and SCPMG employ all physicians that practice in the medical centers, medical office buildings, and satellite offices, as well as the staff members who work in the medical office buildings and satellite offices.

The Plan is organized into two regions, Northern and Southern California, with the regions in turn divided into six service areas in Northern California and fourteen in Southern California. Each service area has one or more medical centers and several medical offices. Each region has a Regional President who reports to the KFHP/KFH National Governing Board. The Plan and KFH have separate boards of directors, however, the same individuals serve on both boards.

There are three levels of authority and accountability for the quality of care and service in Kaiser Permanente:

- **Governing Body/National**: The Plan's Board of Directors and the KFH Board of Directors have ultimate responsibility for the quality of care and service provided to Plan enrollees. These Boards govern each region.

- **Southern California Region**: The Plan/KFH Regional President and the SCPMG Medical Director are jointly accountable to the Boards for the quality of care and service provided in the Southern California region. The Area Medical Center Administrative Teams ("MCAT") of each Medical Center, as well as the Service Area Administrative Teams ("SAAT") of each service area, are accountable to the Regional President, through his Senior Vice President, Chief Operating Officer, and the Medical Director for the quality of care and service provided in each service area.

- **Northern California Division**: The Plan/KFH Regional President and the TPMG Executive Director are accountable to the Boards for the quality of care and service provided in the Northern California region. The Physician-In-Chief ("PIC") and the Service Area Managers are accountable to the Regional President, through his Senior Vice President, for the quality of care and service provided in each service area.

Delivery Model

The three entities that comprise Kaiser Permanente work collaboratively to provide a highly controlled system of health care services. Plan enrollees are encouraged to choose a Primary Care Physician ("PCP") who coordinates and oversee all aspects of their medical care. Most specialist care, with exceptions made only in the case of affiliated providers (described in the next section), is provided through PMG specialists and requires the referral or recommendation of a PCP. Access to certain specialties including obstetrics/gynecology, optometry, psychiatry, and chemical dependency do not require a referral.

Hospital services, whenever possible, are provided by KFH. Enrollees are encouraged to seek emergency care at KFH facilities. Enrollees are also encouraged to use Kaiser outpatient pharmacies staffed by Kaiser pharmacists. Further treatment at KFH facilities, including medication, surgery, or hospitalization, is also obtained through the recommendation of a Kaiser provider.

Referrals for second opinions, specialty care, medications, procedures, and hospitalizations within the Kaiser system generally do not require any prior authorization by the Plan. Enrollees may seek services outside of the Plan only when a service or particular specialty is not available within the Plan. The designated department chief or committee must prior authorize any services to be provided out of Plan.

Contracting Providers/Enrollment

The Plan contracts with TPMG and SCPMG to provide all professional services in the service areas. The medical groups contract with other providers for services that they do not directly provide as follows:

- Tertiary specialists to provide highly specialized services;
- American Specialty Health Plan for chiropractic services for those enrollees with a chiropractic benefit;
- SCPMG contracts with four provider groups and local hospitals in Ventura County and Coachella Valley, which are collectively referred to as the Affiliated Provider Network;
- TPMG contracts with more than 80 provider groups in the Modesto area, which are collectively referred to as the Stanislaus Provider Network; and
- TPMG and SCPMG contract with two hospital intensivist networks (referred to as the Affiliated Intensivist Network) to provide inpatient attending services for enrollees who are admitted, on an emergency basis, to non-Kaiser hospitals.

The following tables summarize the membership of the Plan's contracting provider groups and the size and reimbursement method of the Plan's network.

PROVIDER GROUPS RANKED BY MEMBERSHIP

IPA / Medical Group	Membership as of 8/02	# of Physicians
Southern California		
SCPMG	3,071,330	
Primary care physicians		1,810
Specialists		2,237
Affiliated Provider Network	42,780	
Primary care physicians		213
Specialists		1,296
Northern California		
TPMG	3,113,843	
Primary Care		2,973
Specialists		2,413
Stanislaus Provider Network	80,153	
Primary care physicians		141
Specialists		1,575

PROVIDER NETWORK SIZE AND REIMBURSEMENT METHOD

Type of Provider	# in Southern CA Network	# in Northern CA Network	Reimbursement Method
Primary Care	Over 100 primary sites	Over 100 sites	Capitation
Specialty Care	Same as above	Same as above	Capitation
Inpatient Hospital (including inpatient pharmacy, diagnostics and ancillary services)	53 contracted 12 KFH facilities	39 contracted 14 KFH facilities	Capitation, discount from billed charges, fee-for-service, per diems, case rates
Mental Health	18 contracted 1 KFH facility	46 contracted	Discount from billed charges, fee-for - service, per diems, case rates
Chemical Dependency	11 contracted 2 KFH programs	35 contracted	Per diem, case rates
Emergency Services	51 contracted (2 of	45 contracted	Capitation, discount

Type of Provider	# in Southern CA Network	# in Northern CA Network	Reimbursement Method
	which do not have ER services) 12 owned and operated by KFH	14 owned and operated by KFH	from billed charges, fee-for -service, per diems, case rates
Skilled Nursing Facilities	70 contracted	137 contracted	Discount from billed charges, fee-for -service, per diems, case rates
Home Health Services	27 contracted 7 KFH agencies	35 contracted 12 KFH agencies	Per diem, per visit, per hour, capitation
Burn centers Ambulance Durable medical equipment Orthotics and prosthetics Acute rehabilitation Ambulatory surgery centers	All contracted	All contracted	Per diem, discount from billed charges, fee-for-service, per diems, case rates

Arrangements for Specialty Care

Most specialty care services require a referral by the PCP. As noted above, members may access obstetrics/gynecology, optometry, psychiatry, and chemical medicine specialists without a PCP referral. TPMG and SCPMG require prior-authorization for the specialty services listed below:

- Bariatric surgery
- Out of Plan services
- Organ transplants

The Regional Bariatric Medical Director reviews all referrals for bariatric surgery. The relevant Department Chief and Area Associate Medical Director review referrals for Out of Plan services.

In Southern California, the Regional Transplant Advisory Committees review and approve patient selection criteria and certain referrals for transplants. In Northern California, there is no Regional Transplant Advisory Committee for kidney and kidney/pancreas transplants. The referring physician submits a written request for a referral to the Assistant Physician-in-Chief for the Service Area. The request is then sent to the appropriate contracting transplant center, which decides whether the individual is a candidate for a transplant. If a center refuses the case for a kidney transplant, the enrollee can request a second opinion at another transplant center.

The providers in the Southern California Affiliated Provider Network must obtain prior-authorization of all referrals, with the exception of well-woman care. Fewer specialty services in the Northern California Stanislaus Provider Network require referral and/or prior authorization. Enrollees in this network may obtain obstetrics/gynecology, optometry, psychiatry, and

substance abuse specialty services without a PCP referral. Enrollees can also obtain specialist services within this affiliated network or from a TPMG PCP or specialist without prior authorization from the Plan.

Arrangements for Inpatient Care

There is no prior-authorization requirement for admission by a PMG or affiliated network provider to a Kaiser hospital or a contracted primary hospital. As described above, admissions for bariatric surgery and organ transplants require prior-authorization.

In addition to the KFH hospitals, the Plan contracts with 53 non-Kaiser hospitals throughout the Southern California service area. Twelve of these hospitals serve as primary hospitals to provide geographically accessible inpatient services while the remainder provide overflow inpatient capacity for specific and/or highly specialized services, such as burn care or transplant surgery.

In the Northern California region, the Plan contracts with 39 hospitals in addition to the KFH facilities. Two of these hospitals serve as primary hospitals for Plan enrollees who receive services through the TPMG medical offices in Stockton and Manteca or the Affiliated Provider Network in Modesto. The remaining hospitals provide overflow inpatient capacity for specific services and/or highly specialized services.

Arrangements for Hospital-Related Care

Plan physicians must refer members for home health services. Once a referral is received by a Plan agency, a registered nurse assesses the case to evaluate whether (a) home care is the appropriate level of care; and (b) the Member meets the criteria for home health services as defined by Plan benefits and regulatory requirements. If the assessment indicates that the member's condition has changed since the physician's referral was initiated, or if the member's condition could be more appropriately treated in another setting, the member's physician is contacted to discuss the case.

Prior written authorization is required for Durable Medical Equipment ("DME"). The DME Department at each Medical Center is responsible for the review of DME requests, e.g. wheelchairs.

Arrangements for Emergency Care

All of the Kaiser Medical Centers have 24-hour emergency rooms. Additionally, most of the primary care practices (internal medicine, pediatrics, and family practice) have extended evening hours and weekend hours for urgent/emergent care. Emergency room visits to Kaiser hospitals are covered, regardless of the reasons for the visits. However, emergency room visits to a non-Kaiser hospital are covered only if the reason for the visit meets the prudent layperson rule *and* it is determined that the enrollee could not have gone to a Kaiser facility.
The PMG's developed and implemented the Emergency Prospective Review Program ("EPRP") to admit or transfer Plan enrollees who present themselves to non-Kaiser emergency rooms.

Kaiser EPRP physicians, who are experienced emergency room physicians, review an enrollee's medical condition with the emergency room physician at the non-Kaiser facility. The EPRP physician can send an enrollee's clinical data to the emergency room physician at the non-Kaiser facility.

If the non-Kaiser emergency room physician believes the enrollee needs to be admitted to a non-Kaiser hospital, the Kaiser EPRP physician may arrange for a contracted hospital intensivist to admit and follow the enrollee until the enrollee can be discharged or transferred to a Kaiser hospital. If the non-Kaiser emergency room physician and the EPRP physician agree that transfer to a Kaiser facility is medically appropriate, the EPRP physician arranges the transfer to the Kaiser facility.

Enrollees in the Affiliated Provider Network may receive emergency services at any participating hospital, including Kaiser hospitals. Emergency services at KFH hospitals are covered while emergency services obtained at other hospitals are covered if they meet the prudent layperson rule.

Risk Assumption for Health Care Services

The Plan maintains an exclusive agreement with the PMG's to provide and arrange for the provision of professional services to enrollees. The PMG's are solely responsible for rendering medical services to enrollees in facilities with capital equipment provided and maintained by the Plan. For these services and associated expenses, the PMG's are reimbursed at a previously agreed-upon membership capitation rate as set forth in an itemized budget. The PMG's are fully at risk for about 80% of this budget and share risk evenly with the Health Plan on the remaining 20% of the budget. The shared-risk portion includes items that the PMG's do not control, for example, the costs of certain specialty services obtained out of the Kaiser system.

Delegated Authority to Contracted Provider Groups

SCPMG delegates Utilization Management ("UM") functions including prior authorization, concurrent and retrospective review, medical necessity determination (including issuing denial letters), and emergency services authorization to the four Affiliated Provider Network groups. SCPMG also delegates UM functions to its chiropractic provider network.

TPMG does not delegate any UM functions. Unlike SCPMG, which has contracted with a limited number of IPA's and medical groups, TPMG has contracted directly with individual providers and groups and has maintained responsibility for all UM functions.

Plan Oversight Activities

SCPMG monitors and audits the four Affiliated Provider Network groups to whom it has delegated UM functions. Specific audit activities include an annual audit of UM work plans, quarterly audits of claims processing, monthly or quarterly audit of prior authorization processes, and annual audits of member and provider satisfaction.

In the Northern California region, there are no oversight activities because there are no delegated functions.

SECTION III. OVERVIEW OF SELECTED PLAN OPERATIONAL PROCESSES

UTILIZATION MANAGEMENT

The Plan has a formal utilization review process for select services and procedures, including continued stays in hospitals and skilled-nursing facilities. Most health care services, as discussed above, do not require prior authorization or approval by the Plan. If an enrollee has the benefit, and a Kaiser provider determines that a service or procedure is medically necessary, then it will be covered by the Plan.

In both regions, UM is a shared responsibility of the Plan, KFH and the PMG's. The 2002 UM Program Description describes UM as an "advisory" process. The Plan does not employ a Medical Director. The functions of the SCPMG Medical Director are similar to the functions of a health plan medical director in a non-integrated system.

Committee Structure

In Southern California, the Southern California Resource Management Committee ("SCRMC") reviews and approves UM policies, utilization targets, goals, and improvement activities across the continuum of care. The SCRMC reports to the Southern California Quality Committee ("SCQC"), whose membership includes representatives from SCPMG, KFH and the Plan. Upon approval by the SCRMC, the SCQC reviews and approves these items, which are in turn submitted to the Plan and KFH Boards of Directors for final approval.

In Northern California, the Resource Management Committee ("RMC"), a subcommittee of the Quality Oversight Committee ("QOC"), assures that utilization of services is systematically monitored across all levels of care. The RMC also provides oversight for accreditation activities and consults with medical center staff on UM issues. The RMC reports to the QOC, which oversees UM in the Northern California region. The Associate Executive Director is the physician responsible for oversight of UM in Northern California. The Associate Executive Director and the Plan/KFH Senior Vice President of Operations oversee UM in the service areas.

Utilization Management Directors of the Medical Centers meet monthly to discuss operational issues, develop and approve regional UM policies, and evaluate compliance with regulatory requirements. Regional UM meetings are held quarterly to discuss similar topics.

Appeals/Grievances

If an enrollee requests a service that the Kaiser provider deems medically inappropriate, then the enrollee may file a grievance with the Member Services Department. Satellite offices of the Member Services Department are located at every medical center and medical office building. The enrollee does not receive a denial letter because, in the Plan's system, a denial of service has not occurred. The provider has made a medical determination in response to which the enrollee may file a grievance if s/he is dissatisfied. This process is further described in the Grievance and Appeals section below.

ACCESS AND AVAILABILITY OF SERVICES

Both Northern and Southern California regions have established standards for geographic availability of PCP's and high volume specialties, which are monitored annually by the PMG's. Standards, which are similar in the two regions, are approved by the QOC in Northern California and the SCQC in Southern California. In Southern California, high volume specialties are OB/GYN, mental health, dermatology, orthopedics, and ophthalmology while in Northern California they include OB GYN, mental health, dermatology, ENT, surgery, ophthalmology, and orthopedics.

Both regions have also developed access standards for various types of appointments including primary and specialty care, preventive health, urgent care, and behavioral health. In Southern California, the standards were developed with member input.

Northern California

Patient satisfaction surveys are mailed daily to a sample of Plan enrollees immediately following their medical visits. The survey response rate in 2002 averaged 44.6%. Surveys are tailored to a particular medical visit, including enrollee's name, physician seen, and appointment date. Results are reported quarterly to the QOC. The report presents a summary analysis of all categories of complaints and a more detailed analysis of the five most frequent complaint categories, which constitute approximately 90% of all complaints. Enrollees are also surveyed quarterly on satisfaction with appointment availability. Results are reported to the QOC semiannually.

Three measures are used to analyze complaints about appointment access: the patient survey score for the "convenient access" survey item, the complaint rate, and the actual average appointment wait days for each facility. Further analysis is conducted on data for any facility that scores below average on all three measures.

Finally, the QOC receives a quarterly 28-day Access Report, which shows the average wait time for an appointment by facility and specialty. This report was initiated as a result of a prior Department survey. Departments that do not have appointments available within 28 days of the enrollee's request must submit corrective action plans, which have included hiring additional specialists, contracting with community specialists, expanding clinic hours, offering enrollees appointments at other TPMG facilities, and hiring physician extenders (physician assistants and nurse practitioners) to supplement physician appointments.

Southern California

The Customer Concerns Committee monitors the access-to-care complaint rate. The second quarter 2002 Quarterly Complaint Summary Report showed that while access to appointments was the fifth most frequent complaint, the total number of complaints for the quarter was only 1,036 (against a membership of nearly 3.2 million) and that none of the medical centers had to submit an access corrective action plan.

Physician-headed Access Teams at each medical center monitor appointment availability on a monthly basis. The SCPMG performs a delivery system-wide appointment availability analysis quarterly. These reports show overall trends in appointment availability by type over a three-year period and detailed appointment availability by department and type of appointment. The Access Team submits corrective action plans to the SCQC as necessary to increase appointment capacity. Past corrective action plans have included physician recruitment, relocating physicians to impacted clinic locations, and increasing use of physician extenders. Criteria specific to type of appointment including routine/urgent, psychiatry and addiction medicine have been established to determine when corrective action plans are required.

The SCQC monitors appointment call center performance against the Plan's standards for telephone access and requires corrective action plans and reports when call centers do not meet standards.

For the Affiliated Network Providers, the IPA's and Medical Groups evaluate the availability of appointments annually through primary care provider site reviews.

GRIEVANCES & APPEALS

The Plan has recently revised its grievance policies and procedures to standardize the processes across the two regions, in part due to discussions with the Department's Licensing Division regarding the inclusion of the Independent Medical Review ("IMR") language in the Plan's denial letters. The Plan's HPRS ("HPRS") Department oversees the receipt, handling, and resolution of enrollee grievances. The Vice President for HPRS is the designated Plan officer responsible for the grievance process. Several units under the HPRS Department process enrollee grievances: Member Services; Member Relations; Call Center; Patient Assistance/ Advocacy; and Clinical Review. There are 56 Member Services satellite locations at Medical Centers and facilities where enrollees may file grievances.

The Plan utilizes its grievance system for processing enrollee requests for services other than those that require prior authorization. As mentioned in the overview of the UM program, if an enrollee disagrees with the treating physician regarding a treatment plan the enrollee may file a formal grievance or request with Member Services. On page 167 of the Plan's guide for members, *Your Guidebook, 2002-2003,* under the subtitle "Receive information about your Health Plan," the following language appears: "A formal member/patient grievance may be filed if you feel you are entitled to a specific Health Plan benefit that you have not received."

The Plan has written policies and procedures for handling grievances and appeals. The Plan's standard grievance process is as follows: Member Services forwards the grievances to the

Medical Center Review Committee ("MCRC") for review and determination. The MCRC is to render a decision within fifteen days of receipt of the grievance by Member Services.
If the MCRC denies or modifies a service that an enrollee is requesting because it was not medically necessary, then the member is informed of the denial in writing and given information about his/her appeal rights, including expedited review and the availability of IMR. The notification letter also informs the enrollee that his/her case will be forwarded to the Regional Appeals Committee ("RAC") for reconsideration or appeal. Plan procedures state that the standard grievance process takes 30 days unless the enrollee's condition meets the criteria for expedited review, which is to occur within 72 hours. The 30-day time frame includes the time taken by both committees to review the case.

A physician reviewer with the Patient Advocacy Unit reviews all expedited cases and renders a determination. Plan procedures state that the enrollee is to receive verbal notification immediately after a decision is made and written notification within two days of the decision.

The Plan does not delegate its grievance functions to other organizations.

QUALITY MANAGEMENT

The KFHP/KFH National Governing Board is ultimately responsible for the quality of care and service provided to all Plan enrollees. The Board has delegated authority for quality management to the Quality and Health Improvement Committee ("QHIC"), which in turn delegates the oversight of quality management activities to the SCQC in Southern California and the QOC in Northern California.

The Plan has a sophisticated and well-developed quality-improvement system. The activities of this system include investigating, analyzing, and trending current quality of care and service concerns. These concerns are identified through member complaints and grievances, significant event monitoring, and provider-initiated quality referrals. Corrective actions are initiated with regard to valid concerns. Validity is determined through peer review, root-cause analysis, and/or other quality-improvement methodology. Where corrective actions involve systems and procedure changes, the Plan has mechanisms in place to re-measure their impact.

Quality-improvement activity also focuses on the measurement and improvement of nationally and regionally determined measures of quality-of-care and service, including the Health Employee Data Information Set ("HEDIS") measures. The Plan ranked significantly higher than other health plans in most quality performance indicators, according to the California Cooperative Healthcare Reporting Initiative 2002 Quality Performance report.

Kaiser Permanente devotes substantial staff, analytical and information system resources to quality management and improvement activities. The Plan has earned an excellent accredited status from the National Committee for Quality Assurance.

Southern California
The 2002 Quality Program Workplan for Southern California describes goals and objectives for clinical improvement, and the timeframes for monitoring and completing them.

At the Medical Center level, the MCAT's are responsible for ensuring quality of care and service to the enrollees who have chosen their Medical Center. The MCAT's are accountable to the Senior Vice President/Chief Operating Officer for KHP/HP and the SCPMG Medical Director, both of whom oversee the SCQC. At the Affiliated Provider Network level, the Affiliated Network Providers Activity Committee reviews the performance of the affiliated providers. SCPMG is responsible for auditing the affiliated providers and reports the results to the SCQC.

The following is a partial list of quality-related committees that report to the SCQC:

- QuEST
- Clinical Strategic Goals Steering Group
- Southern California Resource Management Committee
- Significant Event Review Committee
- Regional Credentials and Privileges Committee
- Affiliated Network Providers Activity

Northern California

The 2002 Quality Program Work plan describes goals and objectives for clinical improvement, and the timeframes for monitoring and completing them.

At the Medical Center level, there is a Chief of Quality and Quality Service Leader as well as a Facility Quality Committee in each Medical Center. The Facility Quality Committee is accountable to the Facility Executive Committee, which is accountable to the regional QOC. The QOC members include staff from the Plan, KFH and TPMG. The Executive Director of TPMG and the President of the Northern California region jointly oversee the QOC and are accountable to the national QHIC.

The following is a partial list of quality-related committees that report to the QOC:

- Regional Credentials & privileges Committee
- Information, Confidentiality, privacy & Security Group
- Resource Management Committee, Risk Management/Patient Safety
- Customer Concerns Committee
- Behavioral Health Quality Improvement Committee
- Chiefs of Quality/Quality Service Leaders Committee Significant Event Quality Review

SECTION IV. SUMMARY OF DEFICIENCIES

The following section contains the status of the deficiencies based on the Department's review of the Plan's response to the Preliminary Report. For the deficiencies listed as "not corrected," the Department found that the Plan has not had enough time during the 45-day response period to provide sufficient evidence that its corrective actions have been effective in correcting the deficiency. At the time of the follow-up survey, the Department will review and report on the status of the Plan's efforts to correct those deficiencies. Section V of this the Final Report includes more specific discussion of the current status of the deficiencies listed below.

UTILIZATION MANAGEMENT

Deficiency 1: **The Plan inappropriately denies payment of out-of-plan and out-of-area emergency services and care.** *[Section 1371.4(c)]*
Repeat Deficiency

NOT CORRECTED

Deficiency 2: **The Plan does not consistently provide written responses to enrollees with a clear and concise explanation of the reasons for the Plan's decision or a description of the criteria or guidelines used and the clinical reasons for the decisions regarding medical necessity.** *[Section 1367.01(h) (4); Section 1368(a)(4)]*

NOT CORRECTED

Deficiency 3: **The Plan's Evidence of Coverage and other related enrollee materials do not clearly disclose the process by which an enrollee may obtain authorization for a non-formulary drug.** *[Section 1367.24(b); Section 1367.24(d)]*

NOT CORRECTED

ACCESS and AVAILABILITY

Deficiency 4: **The Plan has not required its contracted provider groups to formally adopt a standard for the ratio of full-time equivalent physicians to enrollees.** *[Rule 1300.51H(i); Rule 1300.67.2(d)]*

NOT CORRECTED

Deficiency 5: **The Plan does not adequately ensure that all enrollees are within 15 miles or 30 minutes driving time of a participating hospital.** *[Rule 1300.51H(ii)]*

NOT CORRECTED

Deficiency 6: **The Plan has not set requirements for hours of operation and for the type of after-hours coverage for its affiliated network primary care providers.** *[Rule 1300.67.2(b)]*

CORRECTED

GRIEVANCES and APPEALS

Deficiency 7: **The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three (3) days of receipt**. *[Rule 1300.68.01(a)]*

NOT CORRECTED

Deficiency 8: **The Plan 's policies and procedures governing the denial of investigational or experimental services for terminally ill enrollees do not require that the enrollee is notified of the specific medical and scientific reasons for denying coverage, alternative services covered by the Plan, if any, or the opportunity for the enrollee to request a conference.** *[Section 1368.1(a)]*

NOT CORRECTED

Deficiency 9: **The Plan has not provided adequate evidence that contested emergency service claims are referred to the medical director, or designated competent licensed health care provider for determination.** *[Section 1370.2]*

NOT CORRECTED

QUALITY MANAGEMENT

Deficiency 10: **The Plan's Affiliated Network Providers do not require hospital-admitting privileges for all their practitioners.** *[Rule 1300.51H(iii)]*

CORRECTED

SECTION V. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

UTILIZATION MANAGEMENT

Deficiency 1: **The Plan inappropriately denies payment of out-of-plan and out-of-area emergency services and care**. *[Section 1371.4(c)]* ***Repeat deficiency.***

Discussion of Findings: The Plan's member handbook, entitled *Your Guidebook, 2002-2003,* clearly states: "Emergency services and care are covered if you were experiencing acute symptoms of sufficient severity, including severe pain, such that you reasonably believed that a failure to obtain immediate medical attention could result in serious jeopardy to health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." The *Guidebook* further states: "If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital." However, the Department found during interviews with the physicians reviewing the out-of-plan/out-of-area emergency claims that an emergency-room visit to a non-Kaiser hospital is covered only if the reason for the visit meets the prudent layperson rule, which is outlined in the member handbook, ***and*** *if it is determined that the enrollee could not have gone to a Kaiser facility.* In effect, the Plan narrows the prudent layperson rule by holding the enrollee responsible for deciding whether or not s/he can go to a Kaiser facility. In these situations, the Plan is denying claims for out of Plan emergency services when, in fact, payment may be appropriate.

During the last survey of the Plan's northern California region conducted approximately three years ago, the Department found that claims staff was not using the prudent layperson rule appropriately to pay out of network emergency claims, resulting in services that were incorrectly denied. As a result of this finding, the Plan was required by the Department to retain an external consultant to conduct an audit of its claims processing procedures.

In addition, during the California Department of Health Services ("DHS") audit of the period 8/1/00 through 7/31/01 for Sacramento Geographic Managed Care, DHS found that the Plan was utilizing geographic proximity criteria ("the time required to reach a Kaiser Permanente facility would mean risk of permanent damage to the patient's health") in applying the prudent layperson rule to out of Plan emergency services. The Plan's corrective action plans were to be implemented no later than June 30, 2002.

As a result of these repeated findings, the Department has conducted a non-routine survey to further assess this issue.

Corrective Action 1: The Plan shall submit documentation of its efforts to correct this deficiency. The Department may also require further information at a later date to assess the status of the Plan's efforts to correct this deficiency.

Plan's Compliance Effort: The Plan submitted a copy of its Claims Continuous Quality Improvement Program Description, which was initiated in 2000 in response to prior deficiencies.

The Plan stated that Kaiser California Claims Administration, HPRS, and an outside physician reviewer audit a sample of paid claims on a monthly basis to determine whether the prudent layperson rule is applied appropriately. The claims denial statistics are reported quarterly to the QOC in Northern California and the SCQC in Southern California. The Plan submitted the claims denial reports for 2002, estimating that the prudent layperson denial rate was approximately 1% and the external physician agreement rate ranged from 88% to 98% for the four quarters.

The Plan also submitted a copy of its Claims Review policy, revised December 26, 2002, which states that a non-clinical claims examiner who identifies a clinical appropriateness issue should refer to the Clinical Review Routing Matrix to determine where to send the claim for clinical review; however, a copy of the Clinical Review Routing Matrix was not submitted with the policy.

The Plan submitted a copy of its Emergent/Urgent Criteria Policy, revised June 28, 2002, which defines emergent care services, urgent care services, and the prudent layperson rule.

Additionally, the Plan submitted the results of an analysis of denied ER claims for the last six months of 2002 at three Northern California hospitals (located within 5.5 miles of a Kaiser facility) and two Southern California hospitals (located 3.4 and 3.2 miles from a Kaiser facility). The Plan stated that the analysis showed that none of the 42 ER visits were denied because members could have sought services at Kaiser hospital facilities.

***Department's Finding Concerning Plan's Compliance Effort*:**
The Department will assess the status of the Plan's corrective action plan during the follow up review.

STATUS: NOT CORRECTED

Deficiency 2: **The Plan does not consistently provide written responses to enrollees with a clear and concise explanation of the reasons for the Plan's decision or a description of the criteria or guidelines used and the clinical reasons for the decisions regarding medical necessity.**
[Section 1367.01(h) (4); Section 1368(a)(4)]

Discussion of Findings: In Southern California, the Department reviewed 33 denial case files including denials issued by affiliated providers that were randomly selected from the Plan's denial log. Of the 33 case files, 13 were denied due to lack of medical necessity. The majority of the denials (92%) did not contain a clear explanation of the Plan's or the delegate's decisions or a description of the clinical criteria or guidelines used to make the determination. The Department reviewed another 10 randomly selected files from the October 2002 denial log. One file did not contain a denial letter while the denial letter in another file did not describe the criteria used to determine that the service was not covered, stating only that *"It does not meet the medical criteria for motorized wheelchair*."

The Department also reviewed a sample of five denial letters sent to enrollees in Southern California between June and August 2002. Of the five denial letters, two were denials due to

lack of medical necessity and three were denials based on lack of benefit coverage. Two of the three benefit denial letters did not specify the provision in the enrollee's contract that excluded coverage.

In Northern California, the Department reviewed 10 contested out-of-area/out-of-plan emergency room service denials. All of these denial letters were unclear. The Plan's template letter defines an emergency but not the reasons why a particular enrollee's condition did not meet the definition. The letter only references the hospital where the services were provided and the amount being claimed but does not describe the medical condition of the enrollee at the time he/she presented to the emergency room.

The Department also reviewed the template letters submitted by the Plan in its October 2002 IMR filing to the Department. One of the letters (Attachment 3) which is used for pre-service coverage determinations by the local medical-center fails to clearly specify the provision in the enrollee's contract that excludes coverage. Similarly, the template letters related to emergency services (Attachments 9, 10, 11 and 12) do not provide clear explanations for denying the service.

The following are examples from actual denial letters reviewed by the Department that illustrate the lack of clarity in the Plan's denial letters:

- Based on the information submitted, this claim has been denied because we have determined that the care you received to evaluate the treatment of your *"out of area is not a covered benefit*" (appears to be an insert) did not meet the definition of an emergency and therefore is not covered under your Kaiser FHP membership. Emergency services and care are covered in circumstances where you experience acute symptoms of sufficient severity, including severe pain, that you reasonably believed that a failure to obtain immediate medical attention could result in serious jeopardy to health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- The Capital Service Area Center Review Committee has met to review your request for reconsideration for Gastric Bypass Surgery. After carefully reviewing your records and other information, we regret to inform you that your request has been denied. After a thorough review of your records, the Committee has determined that you did not meet the clinical criteria for gastric bypass surgery.

Multiple departments including Member Services, Member Relations, Patient Advocacy Unit, Claims, and UM are responsible for issuing denial letters. The Department is concerned about the Plan's failure to standardize language used in its numerous denial letters and to ensure that staff in multiple departments, many of whom do not report directly to the Plan, consistently apply regulatory standards when enrollees are notified that services have been denied.

Corrective Action 2: The Plan shall submit a corrective action plan and provide documentation demonstrating the following:

1. Consistent use of clear and specific language describing the clinical and/or medical reasons for a denial of service, with references to literature and inclusion of Plan published criteria or guidelines (if deemed appropriate);

2. Implementation of procedures to ensure consistent application of regulatory standards among departments involved with issuing denial and resolution letters to enrollees; and
3. Communication with the Affiliated Provider Network providers regarding the deficiencies found in the letters of denial. Proof of adequate oversight along with the modification of any audit tool used by the Plan to monitor implementation of these corrections.

Plan's Compliance Effort: The Plan stated that the California Claims Administration Department will make the following changes to its current denial letter process by December 30, 2003:

- Implement new denial letter codes for issuing medical necessity and non-emergent denial letters.
- Revise denial language to include specific clinical language for medical necessity and non-emergent denials.
- Use Clinical Review Staff to determine what language should be used for medical necessity denials.
- Cite coverage language in benefit denials requiring a clinical assessment.
- Develop of a cross-walk tool for claim processors to use to identify claims that require clinical review.

The Plan provided the following example of revised language used to deny skilled nursing services: "You do not have skilled care needs. According to the 'Skilled Nursing Facility Care' section of your Evidence of Coverage, a Skilled Nursing Facility is covered when a Plan physician prescribes inpatient services and supplies that are medically necessary and above the level of custodial or intermediate care. You need assistance with feed and bathing. This is considered 'custodial care.' Custodial care is not a covered benefit under your Medical and Hospital Service Agreement."

The Plan provided a copy of its Issuance of Notice of Non-Coverage policy and procedure, revised January 8, 2003, which now references the revised reasons for non-coverage. The Plan stated that staff will be trained on the revised language through e-mail, telecommunication and on-site training. The Plan stated that it will revise its audit tools to include more specific indicators on denial language and the use of standard language. The Plan also stated that it was developing a focused Quality Audit of a statistically valid sample of medical necessity and non-emergent denials to ensure that they are referred for clinical review and appropriate denial language is used.

The Plan stated that it is implementing a corrective action plan to ensure that the Affiliated Provider Networks are using correct language in their denial letters. The action plan includes providing the networks with updated template language and letters, educating the networks at the Joint Operations meetings, and reviewing quarterly audit results at Regional Quality Committee meetings.

Department's Finding Concerning Plan's Compliance Effort:
The Department will assess the status of the Plan's corrective action plan during the follow up survey. The Department's review during the follow up survey will include but not be limited to the following: 1) revised medical necessity and benefit denial language in denial letters, 2)

evidence of training conducted for staff members who make UM decisions on the use of appropriate denial language, 3) copies of audit tools used to monitor appropriateness of language used in denial letters, 4) results of audits conducted by the Plan to assess whether medical necessity denials are referred appropriately to clinical review and whether staff is using appropriate language in denial letters to communicate UM decisions to members and practitioners, and 4) evidence showing that the Plan's Affiliated Provider Networks are using correct language in their denial letters.

STATUS: NOT CORRECTED

Deficiency 3: **The Plan's Evidence of Coverage and other related enrollee materials do not clearly disclose the process by which an enrollee may obtain authorization for a non-formulary drug.** *[Section 1367.24(b); Section 1367.24(d)]*

Discussion of Findings: The Department's review of the Plan's enrollee materials, including its evidence of coverage, enrollee handbook, and applicable policies and procedures, concluded that the Plan has not made the process for obtaining authorization for a non formulary drug clear to enrollees. During the interviews, Plan staff stated that if a physician determines that a non-formulary drug would be most beneficial for an enrollee's medical condition, then the physician will prescribe the drug which will be covered pursuant to the enrollee's benefit. Alternatively, if the physician elects to prescribe a formulary equivalent of the non-formulary drug, then the enrollee may file a grievance to request the drug by contacting Member Services. It is unclear however how or if the enrollee is formally informed both of his/her right to file a grievance and how to file a grievance to request a non-formulary drug.

Corrective Action 3: The Plan shall submit a corrective action plan demonstrating that it clearly communicates the process of obtaining authorization for non-formulary drugs to enrollees.

Plan's Compliance Effort: The Plan revised the language in the "Prescription Drug Formulary" section of the *Member Guidebook* to read, "If you wish to have a nonformulary drug that your physician does not determine to be medically necessary, you may file a grievance (or appeal if you are a Medicare Beneficiary) with Member Services." The Plan stated it add this language to its 2004 Evidence of Coverage and send the revised *Member Guidebook* to all members in the third quarter of 2003. The Plan stated that it is the practice of Plan pharmacists to refer enrollees requesting nonformulary drugs to their primary care physicians and to inform enrollees of their right to file a complaint with Member Services.

Department's Finding Concerning Plan's Compliance Effort:
The Plan has not fully implemented its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

ACCESS AND AVAILABILITY

Deficiency 4: **The Plan has not required its contracted provider groups to formally adopt a standard for the ratio of full-time equivalent physicians to enrollees.** *[Rule 1300.51H(i); Rule 1300.67.2(d)]*

Discussion of Findings: Both of the Plan's PMG's have adopted the following standards and measure their networks against these standards annually: (1) the ratio of primary care FTEs to enrollees is equal to or less than 1 FTE for every 2,000 enrollees and (2) the ratio of specialty care FTE's to enrollees is equal to or less than 1 FTE for every 2,000. However, neither medical group has adopted a standard for the ratio of all FTE physicians to enrollees, as required by Rule 1300.67.2(d).

Corrective Action 4: The Plan shall submit a corrective action plan documenting that its contracted PMG's formally have adopted a standard for the ratio of full-time equivalent physicians to enrollees consistent with the 1 FTE physician to 1,200 enrollees requirement of Rule 1300.67.2 (d); or shall propose to the Department an alternate standard, as permitted by Rule 1300.67.2.1(a). The Plan shall ensure that the PMGs' delivery systems are measured against this standard at least annually.

Plan's Compliance Effort: The Plan has stated that it will continue to measure the adequacy of its physician network through the CAHPS® member survey. The survey includes questions about member satisfaction with choosing a primary care physician and the ability to obtain a referral. The Plan stated that it will report the ratio of full-time equivalent physicians to enrollees to the SCQC on an annual basis.

The Plan stated that the TPMG will adopt the standard of 1 FTE physician to 1,200 enrollees and will measure this standard as part of its Annual Availability of Practitioner Report that will be presented to the Regional Quality Oversight Committee in the second half of 2003.

Department's Finding Concerning Plan's Compliance Effort:
The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

Deficiency 5: **The Plan does not adequately ensure that all enrollees are within 15 miles or 30 minutes driving time of a participating hospital.** *[Rule 1300.51H(ii)]*

Discussion of Findings: In Southern California, the Plan uses the standard that there be a contracted or KFH hospital, with an emergency room, within 15 miles or 30 minutes of the enrollee in its evaluation of the facilities' capacity to meet enrollment needs. However, the Plan has not officially adopted this standard nor does it periodically measure its hospital network against this standard.

Corrective Action 5: The Plan shall submit a corrective action plan documenting that its Southern California region has formally adopted standards for the geographic accessibility of hospitals and emergency rooms that are consistent with the 15-mile/30-minute requirements of Rule 1300.51H(d)(ii) and (iv); or, the Plan shall formally propose alternate standards to the Department, consistent with Rule 1300.67.2.1(a).

Plan's Compliance Effort: The Plan stated that it will adopt the standard that all enrollees have access to a contracted or Plan-operated facility with an emergency room within 30 minutes or 15 miles of the enrollee. The Plan will measure this standard annually as part of the Availability Standards Analyses of Time/Distance and Member Satisfaction Report, which will be presented to the SCQC in the second quarter of each year.

Department's Finding Concerning Plan's Compliance Effort:
The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

Deficiency 6: **The Plan has not set requirements for hours of operation and for the type of after-hours coverage for its affiliated network primary care providers.** *[Rule 1300.67.2(b)]*

Discussion of Findings: The Plan does not have requirements for the minimum hours of operation for primary care providers in the affiliated networks. There is a contractual requirement that primary care physician services be available 24 hours a day, seven days a week. However, the Plan has not specified what methods are acceptable for providing such coverage, for example, an answering service or answering machine with physician's pager number.

Corrective Action 6: The Plan shall submit a corrective action plan to establish a policy for the minimum hours of operation for affiliated primary care physicians/sites and for the types of acceptable after-hours coverage. The Plan shall also require that affiliated primary care physicians/sites meet these requirements.

Plan's Compliance Effort: The Plan modified the Affiliated Provider Operations Manual for Southern California to include the requirement that primary care services are available 24 hours a day, 7 days a week. The manual provides examples of ways that the provider can meet this

requirement, including direct referral to an ER or using an answering service that ensures the member receives a call back within a defined period of time. The Plan monitors compliance with this requirement through review and analysis of member complaints, member satisfaction surveys, and annual on site audits of affiliated provider monitoring activities. The Plan modified its 2003 delegation oversight tool to incorporate this requirement.

The Plan modified the Stanislaus Provider Network Manual for Northern California to include a similar requirement that the primary care physician is responsible for after hours care via telephone, pager, and/or answering machine. The revised manual was sent to all network providers.

The Plan stated that it either directly monitors (in Northern California) or requires its delegates to monitor (in Southern California) appointment availability on an annual basis.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

GRIEVANCE SYSTEM

Deficiency 7: **The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three (3) days of receipt.** *[Rule 1300.68.01(a)]*

Discussion of Findings: In Southern California, the Plan's timeliness standards for acknowledging receipt of requests for the expedited review of grievances is within 24 hours; the standard for providing verbal notification of a decision is within 72 hours; and the standard for providing a written notification of a decision is within two calendar days after the decision. These timeliness standards could conceivably exceed the three-day timeframe to up to six days for written notification of a decision. When Plan officials were questioned about these written standards, they acknowledged that the Plan's timeliness standards allow for deviation from the regulatory requirement and confirmed that written notification in some cases did exceed the 3-day requirement.

Corrective Action 7: The Plan shall submit a corrective action plan to modify and implement policies and procedures for providing verbal and written notifications of a decision to enrollees to no more than 72 hours after receipt of the expedited appeal.

Plan's Compliance Effort: The Plan stated that its Expedited Review Unit revised its workflow and added resources to meet the requirement that members be notified of the disposition or pending status of expedited grievances within three days of receipt. The Plan submitted its Complaint, Grievance and Appeal Process & Resolution procedure, effective January 1, 2003, which includes this revision.

Department's Finding Concerning Plan's Compliance Effort:
The Plan did not have adequate time to evaluate the effectiveness of its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

Deficiency 8: **The Plan 's policies and procedures governing the denial of investigational or experimental services for terminally ill enrollees do not require that the enrollee is notified of the specific medical and scientific reasons for denying coverage, alternative services covered by the Plan, if any, or the opportunity for the enrollee to request a conference.** *[Section 1368.1(a)]*

Discussion of Findings: The Plan's policies and procedures state that the Plan will provide the enrollee written notification of the specific medical and scientific reasons for denying coverage of a request for an experimental/investigational service or supply. However, the policies and procedures do not require that the written response will include a description of alternative treatment, services, or supplies covered by the Plan, if any, and an opportunity for the enrollee to request a conference with the Plan.

The Department reviewed the template denial letters (Attachments 4E1, 6E1 and 16E) related to experimental/investigational adverse determinations submitted by the Plan as part of its October 2002 IMR filing to the Department. While the letters consistently included IMR language and the applicable IMR application form as required by the Department, the Department identified the following deficiencies in the IMR template letters:

- The letters do not specify the clinical basis for denying coverage, stating, for example, that "Your EOC (excerpt attached) specifies that experimental or investigational treatments are excluded from coverage. It is for this reason that your request has been denied.";
- A letter issued by the Member Relations Department (Attachment 16E) states, in part, that "the Regional Appeals Committee has denied the request on the basis that the Service requested is experimental or investigational." This statement does not make clear to the enrollee the status of his/her appeal, specifically that the RAC is upholding the initial denial by the Medical Center Review Committee and that the entire process may not take more than 30 days;
- The letters do not provide the enrollee an opportunity to request a conference; and
- The letters do not contain any description of alternative services, if any, that the Plan will cover.

Corrective Action 8: The Plan shall submit a corrective action plan, along with documented evidence, demonstrating that the Plan has modified and implemented procedures, including revising template letters, to address the deficiencies discussed above.

Plan's Compliance Effort: The Plan revised the Southern California Consultation, Referral and Second Opinion process, effective April 14, 2003, to require that denial letters related to investigational or experimental services for terminally ill patients include the following additional components:

- The specific medical and scientific reasons for denying coverage;
- A description of the alternative treatment, services or supplies covered by the plan; and
- Notification to the member of their right to a conference as part of the grievance process. The conference will be held at the earliest possible date or within five days of the request, based on the clinical urgency of the requested treatment as determined by the treating physician, physician reviewer, and/or Associate Medical Director.

Attached to the policy is a template denial letter that includes these components. The Plan stated that it conducted staff training on the policy revisions.

The Plan developed a new policy, entitled "Outside/Internal Medical Referrals, Investigational and Experimental/Terminal Illness," in the Northern California region. The policy became effective April 14, 2003 and contains the same language as the Southern California policy. The Plan stated that it conducted staff training on the requirements of the new policy.

Department's Finding Concerning Plan's Compliance Effort:
The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

Deficiency 9: **The Plan has not provided adequate evidence that contested emergency service claims are referred to the medical director, or designated competent licensed health care provider for determination.** [*Section 1370.2*]

Discussion of Findings: In Northern California, the Department determined that a competent health care provider reviews all out-of-area/out-of-plan emergency claims as evidenced by a duly-signed review referral form. However, in Southern California, the Department could not determine from file review that a physician reviews these claims prior to a denial being issued.

The Department reviewed five out-of-area/out-of-plan emergency service claims that were denied by the Plan. The claims were randomly selected from the Plan's October 2002 claims denial log. Neither the paper nor electronic case files contained any documentation that a competent health care provider reviewed the cases before the Plan issued the denials. When a Plan officer was questioned about this issue during the interviews, she indicated that the claims staff failed to document that a physician reviewer reviewed the claims.

Corrective Action 9: The Plan shall submit a corrective action plan along with documented evidence demonstrating that appropriately licensed health care providers make the denial determinations on contested claims.

Plan's Compliance Effort: The Plan stated that it investigated denied ER claims that were not reviewed by a physician review prior to denial and discovered that an inappropriate denial code had been used. On January 24, 2003, the Plan deleted this code and created a new code to be used for ER denials. The Plan provided training for claims processors on the new denial codes. The Plan stated that it would audit the use of the new denial codes through its routine audits.

The Plan also stated that the actions it proposed for rectifying Deficiency #1 would in turn ensure that physicians review all ER denials involving presenting conditions that did not meet the prudent layperson rule.

Department's Finding Concerning Plan's Compliance Effort:
The Plan did not have adequate time to evaluate the effectiveness of its corrective action plan at the time of the Plan's response to the Preliminary Report. The Department will assess the status of the Plan's corrective action plan during the follow up survey.

STATUS: NOT CORRECTED

QUALITY MANAGEMENT

Deficiency 10: **The Plan's Affiliated Network Providers do not require hospital-admitting privileges for all their practitioners.** *[Rule 1300.51H(iii)]*

Discussion of Findings: In Southern California, affiliated provider groups do not require their physicians to have admitting privileges in contracting hospitals. Rather, when a PCP does not have admitting privileges at a particular contracting hospital, a physician outside of the provider group with admitting privileges to that hospital admits the enrollee. The number of affiliated practitioners who do not have admitting privileges in at least one contracting hospital is not known. The Department is concerned that there may not be an adequate number of affiliated practitioners with admitting staff privileges at contracting hospitals.

Corrective Action 10: The Plan shall submit a corrective action plan to ensure that all of the affiliated provider groups ensure that their physicians have admitting privileges to at least one contracted hospital.

Plan's Compliance Effort: The Plan submitted the following statistics to demonstrate that the Southern California Affiliated Network Providers provide adequate inpatient coverage:

- Seaview Independent Physician Association: Of 248 physicians, 98.8% have hospital admitting privileges.
- Buena Ventura Medical Group: Of 225 physicians, 94.5% have admitting privileges
- Desert Medical Group: Of 78 physicians, 100% have admitting privileges including a hospital admitting team of 6 hospitalists who provide care to group members admitted to the hospital.

- Oasis Independent Physician Association: Of 88 physicians, 100% have hospital privileges including a hospital admitting team of 6 hospitalists who provide care to the group members admitted to the hospital.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

SECTION VI: OTHER ISSUES AND CONCERNS

Subsequent to the on-site portion of the survey conducted in November 2002, and pursuant to Section 1380(h)(1) of the Act, the Department determined that additional information related to the Plan's grievance system and the Plan's process for monitoring specialty care was required to complete the survey. Consequently the Department conducted on-site reviews at the Medical Center level of the Plan's Member Services Departments located in South Sacramento and Baldwin Park, California, on April 24-25, 2003 and April 29-30, 2003, respectively. The Department also requested additional information from the Plan, which the Plan provided on April 24, 2003, pertaining to the Plan's processes for determining the effectiveness of specialty care provided to enrollees.

Member Services/Grievances at Medical Center Level

During the portion of the survey conducted on-site in November 2002, the Department reviewed documents related to the Plan's grievance system and learned that the Plan's grievance system is highly decentralized. The Plan processes member complaints and grievances at Member Service Departments located at 56 separate sites located at the Plan's Medical Centers and medical offices. In order to more fully understand the Plan's grievance system, the Department subsequently reviewed the operation of two of these centers.

Section 1368(a)(5) of the Act requires the Plan to provide members with a clear and concise explanation for the Plan's response to an enrollee's grievance. In order to clearly explain the reason for the Plan's response, the Plan's resolution letters must fully and completely capture the nature of the member's complaint. The Department's review of 70 randomly selected grievance files indicated that in at least 10 cases, resolution letters did not fully or completely address the subject of the member's complaint. This was particularly true in cases where the member's complaint involved a clinical and/or a system issue. For example, one member complained that the physician who saw her son did not address potential symptoms of Attention Deficit Disorder. The Plan's resolution letter to the member stated only that the author of the letter understood that the Chief of the Department had contacted the member and addressed her concerns with her. In another case, the member stated that she thought the physician had missed an abdominal mass. The resolution letter stated that, after reviewing the medical records, the only problem noted was "related to the purported reason for the visit – finger pain."

The Plan's HPRS Division conducts quarterly audits of grievances processed by the Member Services Departments located at the Medical Centers. However, due to staffing constraints (the

Division currently has three full time staff members with other responsibilities in addition to conducting audits), audits have not been conducted within the last year. The most recent audit results provided to the Department were for 2nd quarter 2002. In Southern California, a total of 111 grievance cases were audited in 14 facilities, or an average of 7.9 cases per facility. The overall compliance score was 85.87% for all facilities, compared to a goal of 95%. There was no overall compliance score calculated for the previous quarter. In Northern California, 151 cases were audited in 21 facilities, or an average of 7.19 cases per facility. The overall compliance score was 86.38% compared with 86.12% for 1st quarter 2002. The Plan did not submit data on the total number of grievances received for the period audited, however, the number of grievances audited per facility appears quite low and may not allow the Plan to accurately assess the facility's performance.

The HPRS audit tool does not include an item to assess whether or not the member's complaint was fully documented or described in the resolution letter. There is an item for "nature and/or rationale of resolution clearly documented in system or case file," but this item is not used to evaluate the resolution letter sent to the member.

Required Action: The Plan is to submit a narrative description of its process for ensuring the proper handling of member grievances by the local Member Services Departments to address the issues referenced above. The description should include, but not be limited to the Plan's procedures and work plan for conducting audits over the 18 months, required staff and other resources, how the Plan ensures that all departments follow a consistent set of grievance procedures, and process for requiring corrective action and follow up activity.

Plan's Response to Required Action:

The Plan stated that the Vice President of HPRS is the designated Plan officer who oversees the handling of grievances. It is HPRS' responsibility to ensure that the Member Service Departments are compliant with their handling of member grievances. The Regulatory Compliance Unit of HPRS has four dedicated staff to perform this function.

The Plan stated that a multi-focused approach is used to ensure the correct handling of grievances, including policy management, training, consulting, and auditing. At the local level, the Member Service Departments report to the Quality Service Leaders (QSL). The QSL is a service area position and is accountable for all Member Service departments within the service area. Service areas include two or more Member Service Departments. Member Relations is a regional unit of HPRS and reports to the Vice President of that department.

The Plan has implemented a consistent grievance policy, the Plan's Complaint, Grievance and Appeal Resolution policy (Health Plan Member Rights policy 50-2) to ensure proper handling of grievances. The policy is maintained on a database and website that all Member Service staff can access. Member Services Directors/Managers and staff participate in workgroups to determine changes in the processing of grievances due to requirements from amended or new statutes/regulations. In addition to implementation of this policy, the grievance letter templates used by the Member Services Departments are approved by the Letter Workgroup within HPRS and maintained on the Kaiser database/website. Any changes to the letters are communicated

through emails and, as appropriate, group discussions. Staff is instructed to use only the letters on the database.

The Plan conducts training of the Member Service staff on a quarterly basis. Quarterly, HPRS publishes an on-line document entitled Key Learnings, outlining any recent changes to the grievance procedures along with the answers to frequently asked questions. In addition, HPRS provides other on-line resource tools for Member Service staff to use in the handling of grievances, including a database containing more detailed explanations of how to handle a grievance, benefit information, and evidence of coverage documents.

The Plan's HPRS Department also provides real-time consultation for Member Services staff through telephone or email. The HPRS staff routinely attend the Southern California Region's Member Service Directors' monthly meetings and Northern California Region's Member Services Managers' bimonthly meetings. Aging reports of open grievance cases are provided monthly to the Member Service Directors/Managers, allowing for a prioritization of case handling.

Finally, the Plan through HPRS, conducts compliance audits of grievances. In early 2002, the audit methodology was revised from a validation audit process to an independent audit on a quarterly basis. During the first quarter, the work plan was presented to the Member Service Directors/Managers. The Plan submitted its 2002 audit work plan. The audit was then performed for the first and second quarter. During 2002, the Plan experienced multiple surveys that required auditing grievance files in the second and fourth quarters. These audits were performed in lieu of routine audits. The results of the audits were shared with the Member Service Managers/Directors and the QSLs and corrective action plans were developed to correct the deficiencies. Along with the survey activity, there were other regulatory changes which resulted in significant changes to the Plan's grievance procedures and further changes in the audit tool. The final changes were determined in October 2002.

The revised audit process was implemented in 2003. Revisions included use of HEDIS methodology for selecting case files, revision of the audit tool, and conducting complete and focused audits in alternating quarters. This audit cycle was implemented beginning with the 1st quarter 2003. The Plan submitted its 2003 grievance audit work plan. The results of the audits are shared with the QSLs and the Member Service Directors/Managers. Departments falling below threshold must develop corrective action plans. Regulatory Compliance in HPRS and the regional quality committees monitor of the corrective action plans. As appropriate, further actions are requested if compliance is not achieved.

***Department's Finding Concerning Plan's Response*:**
The Plan provided a general description of its process for ensuring the proper handling of member grievances by the local Member Services Departments. The Plan also submitted its 2003 audit work plan showing that two audits have been conducted in 2003 (2nd and 3rd quarter) with a third scheduled for the 4th quarter. However, the Plan's response did not address several of the issues raised by the Department, which include the following: 1) whether the Plan has devoted adequate staff resources to its grievance audit program, 2) how the Plan ensures that it audits an adequate number of grievances, and 3) revision of the audit tool to assess whether the member's complaint was fully addressed in the Plan's resolution letter. The Department will

review the Plan's efforts to address these specific issues, along with the results and corrective actions of audit findings, during the follow up survey.

Monitoring Appropriateness and Effectiveness of Specialty Care

Section 1367.01 of the Act requires that the Plan establish a process by which it prospectively, retrospectively and concurrently reviews and approves, modifies, delays and denies based in whole and part on medical necessity, requests by providers of health care services for Plan enrollees. Because the Plan's process for authorizing or denying health care services applies only to out of Plan referrals, transplants, bariatric surgery and DME, the Plan does not use a formal referral/authorization process for reviewing the bulk of specialty care provided to enrollees. Additionally, the Primary Care Physician rather than the Plan makes the determination about whether or not the enrollee requires specialty care. If the PCP and the enrollee do not agree about the need for a specific specialty service, the enrollee does not receive a written denial notice because in the Plan's system the physician has made a clinical determination, not a denial of service. Enrollees in these situations may not realize that they are entitled to appeal the adverse decisions or request independent medical review.

In order to fully review this aspect of the Plan's system, the Department requested additional information from the Plan about how the Plan monitors the appropriateness and effectiveness of specialty care. The Plan stated that it assures provision of appropriate and effective care as follows:

- Imposing no barriers to specialty referrals
- Surveying Plan physicians
- Monitoring and responding to member grievances
- Monitoring and measuring access, including surveying Plan members
- Credentialing physicians
- Monitoring quality data through HEDIS indicators, disease management, and sentinel events
- Identifying and initiating specific improvement opportunities

The Plan further stated that these measures allow it to determine whether PCP's are appropriately referring members to specialists, whether members have appropriate access to specialty care, and whether specialists provide appropriate follow up care. These measures also assist the Plan to address issues of over- and under-utilization.

To the extent that these activities are not fully described in other sections of this Preliminary Report, they are described below.

Referral Process

When the PCP refers the enrollee to a specialist, the referral is a "standing referral" which allows the member to see the specialist as long as the specialist determines that it is medically appropriate. The Plan stated that there is no financial incentive not to refer a member to a specialist when necessary. Enrollees may also self refer to certain specialties, such as obstetrics/gynecology, optometry, psychiatry, and chemical dependency. Specialists can refer enrollees to another specialist as medically appropriate without requiring the enrollee to obtain a

referral from the PCP and/or Plan. Specialists may order laboratory and radiology services without prior authorization by the Plan.

Surveying Plan Physicians

The Plan surveys its physicians with regards to whether or not they believe they have the ability to provide necessary care without barriers imposed by the Plan. The Plan stated that survey results indicate a high level of satisfaction in this regard.

Monitoring Availability and Accessibility of Providers

The Plan conducts various member surveys to assess enrollee perception of access to care, with the most prominent being the Consumer Assessment of Health Plan Survey (CAHPS). The California Cooperative Healthcare Reporting Initiative (CCHRI) uses the CAHPS survey to compare California health plans. The Plan stated that the overall results of the CAHPS surveys demonstrate that the Plan generally scored above the CCHRI average in measures related to member satisfaction with access to care. The Plan stated that it earned some of its highest marks for treating members with cardiac conditions, including surgical interventions.

The Plan also conducts quality improvement activities to monitor access to specific specialty services. For example, in Northern California, the radiology and surgery departments sponsor the Access to Biopsy Quality Improvement Activity. Quality indicators are used to monitor the percent of biopsies performed in less than 15 days after members receive an alert code 4 or 5 mammogram. Similarly, in Southern California, the Regional Breast Cancer Committee sponsors the work to monitor the time it takes to perform biopsies after members receive an alert code 4 or 5 mammogram. The radiologists become directly involved with the members' care and arrange follow up care, thereby reducing the time that it would take if the radiologists had to communicate the information to the PCP who then had to make arrangements for the member's follow up care.

All of the information gathered through these activities is reported annually to the applicable regional quality committee and to the quality committee of the Board.

Credentialing

The Plan stated that it also monitors the appropriateness of specialty care by evaluating the competency of each physician through the physician credentialing process. The Plan's credentialing process includes an assessment of the competency of each individual primary care physician and specialist and includes review of member grievances and peer review issues. Physicians are credentialed initially when they join the Plan's network and are re-evaluated every two years.

Monitoring Specialty-Specific Quality Indicators

The Plan conducts other monitoring activities to evaluate specific quality indicators, events, or diseases. This monitoring provides the Plan with valuable information on specific issues related to specialty care.

The Plan's HEDIS measures that monitor the appropriateness and effectiveness of specialty care and diagnostic testing include but are not limited to cervical cancer screening, breast cancer

screening, appropriate use of asthma medications, and cholesterol management after an acute cardiac event.

The Plan reports its HEDIS results to the regional quality committees annually. Based on HEDIS results, the Plan identifies and implements performance improvement activities to encourage utilization of appropriate services. For example, in Northern California the Plan provides a preventive health prompt summary to the member receives when he/she registers for an appointment. The prompt summary indicates which preventive services the member needs. In addition, targeted outreach letters are sent to members for a number of preventive health and population-based care initiatives (e.g., childhood immunizations and mammography). Similarly, in Southern California, if a member needs preventive services, a letter is provided to the PCP to verify the information with the member and order the appropriate tests. For certain populations with chronic conditions, a detailed clinical information sheet with specific recommendations is faxed to the PCP on the day of the member's appointment.

Another way that the Plan monitors appropriateness of care and encourages utilization of appropriate services is through disease management programs. The goal of these programs is to identify and treat members as early as possible in the course of their disease. These programs usually involve specialty care services. The disease management programs use established, evidence-based guidelines that suggest when certain practices should be performed when managing certain chronic conditions. The disease management programs monitor tests, medications, and regular blood work for members with chronic conditions.

The regional quality committees monitor the appropriateness of care provided to members participating in these programs by reviewing reports (produced quarterly and distributed to the local medical centers), which contain results of the measures used to assess the effectiveness of care provided. The reports allow for comparisons between medical centers across quality of care and efficiency measures.

Examples of diseases and measures comprising disease management activities include, but are not limited to hospital discharge and readmission rates, diabetes, and cardiovascular disease.

The Plan also monitors the appropriateness of specialty care by monitoring sentinel events. The Plan stated that its sentinel event management and reporting process is used consistently across all regions of the Kaiser Permanente Medical Care Program. The process identifies unexpected occurrences that result in, or present the risk of, loss of life or bodily harm or disruption of clinical operations. Depending on the severity and the nature of the event, designated Plan leadership is notified immediately, and an appropriate systems analysis is performed. These events are tracked by each regions' quality committee and the applicable quality department to ensure that a timely analysis is performed and that appropriate actions are implemented. Additionally, these events are trended to identify opportunities for region-wide performance improvement initiatives. The analysis and corrective action plan are ultimately reported to the quality committee of the Board.

Improvement Opportunities

Through the activities described above, the Plan stated that it monitors the appropriateness of specialty care and ensures access to this care by the Plan members. When issues are identified, the Plan has a process to implement opportunities to improve care, including implementing corrective action plans. The Plan oversees the implementation of these activities and may exercise its authority at any time, and through participation on the regional quality committees. The regional quality committee may either approve a recommended action, request more information to substantiate the recommended action, or require the applicable medical department to develop an alternative action plan. If the regional quality committee requests an alternative action plan, the medical department will then determine the appropriate corrective actions to meet the defined expectation or outcome as directed by the regional quality committee or subcommittee. The medical department must submit the alternative corrective action plan for approval by the regional quality committee. The issue will continue to be monitored by the regional quality committee until it is resolved. If the quality issue is not resolved to the satisfaction of the regional quality committee, the committee may elevate the issue to senior leadership (Plan and Medical Group) and to the quality committee of the Board.

Required Action: No further actions required at this time.

A P P E N D I X A

List of Surveyors

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Ann Vuletich, MPH	Associate Health Plan Analyst

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES:	
Rose Leidl, RN, BSN	Project Manager, Grievance & Appeals
Bernice W. Young	Program Director, Grievances and Appeals
Laurence Ikeda, MD	Utilization Management
Rodney Armstead, MD	Utilization Management
Mark Leveaux, MD	Quality Management
Ruth Martin, MBA	Access & Availability
Lynnette Hutcherson, RN	Case File Reviewer

A P P E N D I X B

List of Staff Interviewed

The following are the names and titles of key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative offices in Pasadena, California from November 4 to 8, 2002:

Kaiser Southern CA Region

Name	Position Title	Affiliation (KFHP, MG, TPMG, Others (Specify)
Gregory Adams	Senior Vice President, Operations	KFHP/H
Andy Amster	Director Quality Measurement and Evaluation	
Eula R. Anyiwo, RN, MPA	Assistant Director, Service and Access	SCPMG
Anthony A. Barrueta	Senior Counsel, Government Relations	
Catherine Berman	Director, Professional Contracts and Network Management	
John Brookey, M.D.	Assistant to the Associate Medical Director	SCPMG
Stan Cias	Regional Director, Utilization Management	SCPMG
Judy Culmer	Consultant, Regulatory Compliance	KFHP
Carolyn Days	Vice President, California, Quality and Service	SCPMG
Kurt Drumheller	Director, Member Relations	Kaiser Foundation Health Plan, Southern California
Kathy Grannan, MD	Medical Director, HPRS	TPMG/KFHP
Kay Simmons-Gilpatric	Assistant Director, Network Quality/Quality Assurance	SCPMG
Steven W. Gray, Pharm. D., J.D.	Regulatory Compliance and Professional Affairs Leader	KFHP
Charles Kellerman, MD	Physician Director, Continuing Care	SCPMG
Lisa Kolton	Vice President, HPRS	KFHP
Bruce Locke, MD	Medical Director	SCPMG
Jocelyn Lundquist	Senior UM Consultant, UM	
Sharon A. Mesker	Director, Quality Management	SCPMG
Cheryl McCaughan	Assistant Director, Member Relations	KFHP

Name	Position Title	Affiliation (KFHP, MG, TPMG, Others (Specify)
Susan McGee	Managing Director, Advocacy and Benefits	KFHP
Susan Nowell	Director, Credentialing	SCPMG
Martha Sikkens	Director, Regulatory Compliance	Kaiser Foundation Health Plan/Hospitals (KFHP)
Sheila Tucker, RN	Clinical Review Leader	

The following are the names and titles of key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative offices in Oakland, California from November 18 to 22, 2002:

Kaiser Northern CA Region

Name	Position Title	Affiliation (KFHP, MG, Others (Specify)
Marilyn Ammons	Director, Member Relations, HPRS	KFHP
Karen Brisnak	Lead Consultant, Department of Quality and Utilization	TPMG
Sarah Brown	Operations Supervisor, Regional Credentialing	KPNC
Kristin Chambers	Compliance Director	TPMG
Stan Cias	Regional Director	SCPMG
Paul Feigenbaum, M.D.	Regional Medical Director, Hospital & Continuing Care Operations	TPMG
Dale Grahn, M.D.	Regional Director, UM,	TPMG
Kathy Grannan, MD	Medical Director, HPRS	TPMG/KFHP
Karen Grisnak	Lead Consultant of Quality, Dept of Quality and Utilization	TPMG
Lisa Koltun	Vice President, Kaiser HPRS	KFHP
Debbie Krasinkiewicz	Regional Utilization Management Leader	KFH/HP
Winston Lawrence	Consultant, HPRS	TPMG
Sharon Levine, M.D.	Associate Executive Director	TPMG
Bruce R. Locke, M.D.	Medical Director Health Plan Clinical Review	TPMG

Name	Position Title	Affiliation (KFHP, MG, Others (Specify)
Phil Madvig, M.D.	Associate Executive Director	TPMG
Susan McGee	Managing Director, Advocacy, HPRS	KFHP
Julie Petrini	Senior Vice President, Operations	KFH/HP
Mike Ralston, M.D.	Medical Director of Quality Implementation	TPMG
Martha Sikkens	Director, Regulatory Services	KFHP
Vicki Stanley	Assistant Director, Member Relations, HPRS	KFHP
Sonya Struc	Sr. Consultant for Quality, Department of Quality and Utilization	TPMG
Cathy Wada	Practice Leader, Department of Quality and Utilization	TPMG
Mary Ward	Director, Regional Credentialing	KPNC
Joann K. Zimmerman	Senior Vice President, Operations	KFH/HP

A P P E N D I X C

Glossary

Term	Acronym	Definition
Affiliated Intensivist Network	AIN	A network of physicians contracted with SCPMG to provide inpatient services for members in contracted non-KFH.
Affiliated Network Provider		Provider groups contracted by SCPMG that provide professionals medical services to enrollees residing in the West Ventura/Coachella Valley Service Areas: Desert Medical Group; Oasis IPA; SeaView IPA; and Buenaventura Medical Group.
Area Associate Medical Director	AAMD	Senior SCPMG leader of each area medical center (KPSC-Glossary of Terms 2002)
Associate Executive Director	AED	The physician responsible for the oversight of utilization management; partners with the Sr. VP of Operations to oversee the Service Area and local utilization functions. (KPSC-Glossary of Terms 2002)
Bariatric surgery		A surgical procedure that reduces the size of the gastric reservoir, with or without a degree of associated malabsorption in the treatment of long term weight control for the morbidly obese (American Society of Bariatric Surgery, 2001)
Base Contractual Payment		The rate making and operating budgets that are negotiated between Medical Groups and KFHP for payment of total Medical Group operating expenses plus one half of planned at Risk Compensation (KPSC-Glossary of Terms 2002)
California Cooperative HEDIS Reporting Initiative	CCHRI	A California consortium of Health Plans, providers and purchasers developing a statewide, standardized HEDIS report (KPSC-Glossary of Terms 2002)
Cost Allocation Program	CAP	Cost allocated to the Medical Group and Hospitals by KFHP for use of buildings, equipment and support services (KPSC-Glossary of Terms 2002)
Customer Concerns Committee	CCC	A KPNC subcommittee of the QOC that is responsible for analyzing data related to complaints, grievances and appeals regarding patient care, access, member satisfaction and service. The intent of this analysis is to identify problems that will improve the quality and service throughout KPNC (KPNC – Program Description 2003)
Emergency Prospective Review Program	EPRP	A program developed and implemented by KFHP to manage the utilization of emergency services and facilitate continuity of care among enrollees admitted to non-Kaiser Hospitals.
Executive SC Resource Management Team	E-SCRMT	A team chaired by the AMD-CS and the KFH-SC President that provides sponsorship to utilization/resource management activities in Southern California. (KPSC – QM Program Description 2002)
Health Plan Employer Data Information Set	HEDIS	Sponsored by NCQA, a set of data to be reported by Health Plan to employers (KPSC-Glossary of Terms 2002)
Interregional New	INTC	A committee in KPNC and KPSC that considers issues arising in all areas of medical technology; research and analyze data and

Term	Acronym	Definition
Technologies Committee		information for new technologies; evaluates the medical appropriateness of new technologies; services as an ad hoc advisory group to departments; and makes final decision regarding inclusions as a health plan benefit (KPSC – QM Program Description 2002)
Kaiser Foundation Hospitals	KFH	An entity of the Kaiser Permanente Medical Care Program comprised of non-profit hospitals which provide hospital services to the KFHP enrollees under the Hospital Services Agreement between KFH and KFHP (KPSC-Glossary of Terms 2002)
Kaiser Foundation Health Plan	KFHP	A nonprofit public benefit California corporation that contracts with individuals and groups to provide or arrange for comprehensive prepaid health care benefits; is a federally qualified health maintenance organization, and a California-licensed Knox-Keene health care service plan; contracts with Kaiser Foundation Hospitals (KFH) to provide hospital services (KPNC – Program Description 2003
Kaiser Permanente		An integrated group model HMO composed of three distinct entities: Kaiser Foundation Hospitals; Kaiser Foundation Health Plan; and "The Medical Group", (The Permanente Medical Group in Northern California (TPMG) and Southern California Permanente Medical Group in Southern California (SCPMG)).
Kaiser Permanente Northern California	KPNC	A geographical region of KPMCP; comprised of six service areas in Northern California: Capital, East Bay, Central California, Golden Gate, North Bay and South Bay. KFHP, KFH and TPMG share responsibilities to provide and coordinate appropriate and effective quality patient care, medical management and member involvement in care ((KPNC – Program Description 2003)
Kaiser Permanente Southern California	KPSC	A geographical region of KPMCP comprised of six service areas in Southern California: Inland Empire, Metropolitan Los Angeles, Orange County, San Diego County, Tri-Central (Baldwin Park, Harbor City, Bellflower), the Valleys (Woodland Hills, Kern County and Panorama City) and West Ventura County. KFHP, KFH and SCPMG share responsibilities to provide and coordinate appropriate and effective quality patient care, medical management and member involvement in care
Medical Center Administration Team	MCAT	The leadership and senior management team of a medical center; the team is comprised of the AAMD, MGA and HA (KPSC-Glossary of Terms 2002)
Medical Directors Quality Committee	MDQC	A national level committee that develops standards to review quality of care and service in each region which are reported to the Boards of QHIC (KPNC – Program Description 2003)
Medical Group Administrator	MGA	Senior leader of area medical group operations (KPSC-Glossary of Terms 2002)
Operations Management Group	OMG	A TPMG committee that oversees day to day operations of the medical group; chaired by the TPMG Executive Staff and Physicians-in-chief and reports to the QOC (KPNC – Program Description 2003)
Operations		A TPMG subcommittee of the OMG/QOC that addresses strategic

Term	Acronym	Definition
Management Group Subcommittee on Quality		level quality issues, such as the review and approval of TPMG annual clinical quality goals and clinical practice guidelines (KPNC – Program Description 2003)
Operations Management Group Subcommittee on Services and Access		A TPMG subcommittee of the OMG/QOC that addresses member satisfaction issues through the development of programs aimed at promoting access to appropriate care and service (KPNC – Program Description 2003)
Pharmacy and Therapeutic Committee	P&T	A KPNC/KPSC committee that develop and revise the Drug Formularies and make recommendations relating to pharmacy policy (KPSC – QM Program Description 2002) (KPNC – Program Description 2003)
Primary Care Practitioner	PCP	A physician rendering primary care services to members with a specialty in family practice, general internal medicine or general pediatrics (KPSC-Glossary of Terms 2002)
Quality Evaluation Support Team	QuEST	A KPNC/KPSC subcommittees of the KPNC-QOC and KPSC-SCQC that provides analytical, consultative and support staff services; is responsible for performing in depth analysis of reports, reviewing and approving routine reports including those from the KPNC-QOC and KPSC-SCQC subcommittees. (KPSC – QM Program Description 2002)
Quality and Health Improvement Committee	QHIC	A national level Board committee that has ultimate accountability in the health plan for quality and service, and to oversee quality of care and service delivery to all members (KPSC – QM Program Description 2002)
Quality Oversight Committee	QOC	KPNC - a committee that Reviews and evaluates the results of quality improvement actions; recommends KPNC policy decisions; institutes needed actions; ensures follow up occurs (KPNC – Program Description 2003)
Regional Credentials and Privileges Subcommittee	RCPS	A KPNC subcommittee of the QOC that oversees credentialing and privileging, granting of approval to participate and recredentialing of affiliated practitioners and oversees the actions of the local credentials and privileges committees (KPNC – Program Description 2003)
Regional Credentials and Privileges Subcommittee	RCPC	A KPSC subcommittee of the SCQC that sets the vision, goals, priorities, outcome, scope for SC; oversees credentialing and privileging, granting of approval to participate and recredentialing of affiliated practitioners and oversees the actions of the local credentials and privileges committees (KPSC – QM Program Description 2002)
Resource Management Committee	RMC	KPNC - a subcommittee of the QOC, reports periodically to the QOC; purpose of the RMC is to promote the development of utilization management strategies and activities, provide oversight to KPNC accreditation preparation, monitor utilization and compliance, consult to Medical Center staff on UM issues, and

Term	Acronym	Definition
		facilitate change to realize improvements in utilization (KPNC – Program Description 2003)
Resource Management Group	RMG	A KPNC workgroup that acts as the analytic arm of the RMC; is responsible for the summarizing and focusing of the UM reports submitted to the RMC (KPNC – Program Description 2003)
Risk Management/ Patient Safety Subcommittee		A KPNC subcommittee of the QOC that sets the visions, goals, priorities, and oversight for Risk Management and Patient Safety; the work is organized to measurably reduce risk of patient injury and improves patient safety and quality in prioritized areas (KPNC – Program Description 2003)
Service Area	SA	Area Medical Centers are divided into geographic service areas (SAs) for administrative and customer service purposes; the leadership and management team for each SA is comprised on the AAMD, MGA, HA and a SAM for each Area/ Medical Center within the service area (KPSC-Glossary of Terms 2002)
Service Area Administrative Team	SAAT or SALT	The leadership and senior management each for each Service Area; the team is comprised of the AAMD, MCA, HA and SAM; also known as the Service Area Leadership Team (SALT) (KPSC-Glossary of Terms 2002)
Service Area Manager	SAM	KFHP senior leader in each of the six SA's (KPSC-Glossary of Terms 2002)
Southern California Permanente Medical Group	SCPMG	One of the three SC Regions of the KPMCP, namely the physician partnership and its employees that provides the medical care to KFHP enrollees through mutually exclusive contracts (KPSC-Glossary of Terms 2002)
Southern California Quality Committee	SCQC	A KPSC committee that Reviews and evaluates the results of quality improvement actions; recommends KPSC policy decisions; institutes needed actions; ensures follow up occurs; reports to the President and Medical Director (KPSC – QM Program Description 2002)
Southern California Resource Management Committee	SCRMC	A KPSC subcommittee of the SCQC that serves as the review, oversight, and approval body for utilization/ resource management/ continuing care polices, utilization targets, goals and improvement activities for SC (KPSC – QM Program Description 2002)
Southern California Resource Management Performance Improvement Group	SCRM-PIG	A KPSC subcommittee of the SCRMC that provides planning, an analysis and recommendations related to UM activities to the E-SCRMT and SCRMC (KPSC – QM Program Description 2002)
Stanislaus Provider Network		TPMG expansion project for central California; TPMG has contracted with eight core primary care groups and approximately 65 specialty and ancillary provider groups, totaling more than 300

Term	Acronym	Definition
		physicians and other licensed independent practitioners to provide care for Kaiser enrollees residing in the Modesto area (KPNC – Program Description 2003)
The Permanente Medical Group	TPMG	KPNC – a multi-specialty professional physician corporation contracted by KFHP to provide or arrange medical and other health care services for health plan members.

A P P E N D I X D

Plan's Medical Center Locations

Region	Service Area	Medical Center
Southern California	**Inland Empire**	• Fontana
		• Riverside
	Metropolitan Los Angeles	• Los Angeles
		• West Los Angeles
	Orange County	
	San Diego County	
	Tri-Central	• Baldwin Park
		• Harbor City
		• Bellflower
	The Valleys	• Kern County
		• Panorama City
		• Woodland Hills
	West Ventura County	• Oxnard
		• Ventura
	Coachella Valley	• Indio
		• Joshua Tree
		• Palm Springs
		• Rancho Mirage
		•
Northern California	**East Bay**	• Fremont
		• Hayward
		• Oakland
		• Richmond
		• Union City
	Golden Gate	• San Rafael
		• Novato
		• Petaluma
		• San Francisco
		• South San Francisco
		• Santa Rosa

Region	Service Area	Medical Center
	North East Bay	• Antioch
		• Fairfield
		• Martinez
		• Napa
		• Park Shadelands
		• Pleasanton
		• Vacaville
		• Vallejo
		• Walnut Creek
	South Bay	• Campbell
		• Gilroy
		• Milpitas
		• Mountain View
		• Redwood City
		• Santa Clara
		• Santa Teresa
	Central CA	• Fresno
		• Modesto
		• Stockton
	Capital	• Davis
		• Fair Oaks
		• Folsom
		• Point West
		• Rancho Cordova
		• Roseville
		• Sacramento
		• South Sacramento

A P P E N D I X E

Applicable Statutes and Regulations

The following specific citations are used in this Routine Medical Survey Report as the basis for the deficiencies:

UTILIZATION MANAGEMENT

Deficiency 1: **The Plan inappropriately denies payment of out-of-plan and out-of-area emergency services and care**. *[Section 1371.4(c)]*
Repeat deficiency.

Citation: ***Section 1371.4(c)*** *states in relevant part that "Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition."*

Deficiency 2: **The Plan does not consistently provide written responses to enrollees with a clear and concise explanation of the reasons for the Plan's decision or a description of the criteria or guidelines used and the clinical reasons for the decisions regarding medical necessity.**
[Section 1367.01(h) (4); Section 1368(a)(4)]

Citation: ***Section 1367.01(h)(4)*** *states in relevant part that "responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity."*

Citation: ***Section 1368(a)(4)*** *states in relevant part that "If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage."*

Deficiency 3: **The Plan's Evidence of Coverage and other related enrollee materials do not clearly disclose the process by which an enrollee may obtain**

authorization for a non-formulary drug. *[Section 1367.24(b); Section 1367.24(d)]*

Citation: ***Section 1367.24 (b)*** *states that "Any plan that disapproves a request made pursuant to subdivision (a) by a prescribing provider to obtain an authorization for a non-formulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02."*

Citation: ***Section 1367.24(d)*** *states that "The process described in subdivision (a) by which enrollees may obtain medically necessary non-formulary drugs, including specified timelines for responding to prescribing provider authorization requests, shall be described in evidence of coverage and disclosure forms, as required by subdivision (a) of Section 1363, issued on or after July 1, 1999."*

ACCESS AND AVAILABILITY

Deficiency 4: **The Plan has not required its contracted provider groups to formally adopt a standard for the ratio of full-time equivalent physicians to enrollees.** *[Rule 1300.51H(i); Rule 1300.67.2(d)]*

Citation: ***Rule 1300.51H(i)*** *states "Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees."*

Citation: ***Rule 1300.67.2(d)*** *states that "The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees... or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees."*

Deficiency 5: **The Plan does not adequately ensure that all enrollees are within 15 miles or 30 minutes driving time of a participating hospital.** *[Rule 1300.51H(ii)]*

Citation: ***Rule 1300.51H(ii)*** *states that "In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services."*

Deficiency 6: **The Plan has not set requirements for hours of operation and for the type of after-hours coverage for its affiliated network primary care providers.** *[Rule 1300.67.2(b)]*

Citation: ***Rule 1300.67.2(b)*** *states that "Hours of operation and provision for after-hour services shall be reasonable."*

Deficiency 7: **The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three (3) days of receipt.** *[Rule 1300.68.01(a)]*

Citation: ***Rule 1300.68.01(a)*** *states in relevant in part, that "every plan shall include within its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include the following: (2) The plan shall provide the complainant and the Department with a written statement on the disposition or pending status of the urgent grievance within three (3) days of receipt."*

Deficiency 8: **The Plan 's policies and procedures governing the denial of investigational or experimental services for terminally ill enrollees do not require that the enrollee be notified of the specific medical and scientific reasons for denying coverage, alternative services covered by the Plan, if any, or the opportunity for the enrollee to request a conference.** *[Section 1368.1(a)]*

Citation: ***Section 1368.1(a)*** *states that "A plan that denies coverage to an enrollee with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, shall provide to the enrollee within five business days all of the following information:*
(1) A statement setting forth the specific medical and scientific reasons for denying coverage.
(2) A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
(3) Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

Deficiency 9: **The Plan has not provided adequate evidence that contested emergency service claims are referred to the medical director, or designated competent licensed health care provider, for determination.** [*Section 1370.2*]

Citation: ***Section 1370.2*** *states in relevant part that* ***"****Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and, if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on the appealed claim. If the health care provider or medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim. For the purposes of this section, "competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized."*

QUALITY MANAGEMENT

Deficiency 10: **The Plan's Affiliated Network Providers do not require hospital-admitting privileges for all their practitioners.** *[Rule 1300.51H(iii)].*

Citation: ***Rule 1300.51 H(iii)*** *states "Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.****"***
