DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JULY 10, 2014
DATE ISSUED TO PUBLIC FILE: JULY 21, 2014

Final Report of a Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Health Plan
July 10, 2014

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EXECUTIVE SUMMARY

On June 20, 2012, the California Department of Managed Health Care (the "Department") notified Kaiser Foundation Health Plan, Inc. (the "Plan") that its Routine Medical Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from September 10, 2012 through September 13, 2012 and October 1, 2012 through October 4, 2012. The Department completed its investigatory phase and closed the survey on March 14, 2013.

The Department assessed the following areas:

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

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

2012 SURVEY DEFICIENCIES

#	DEFICIENCY STATEMENT	
	GRIEVANCES AND APPEALS	
1	**The Plan did not maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification where appropriate.** Section 1368(a).	**Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
2	**The Plan did not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee' appointments are offered within the regulatory timeframes.** Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(5); Rule 1300.67.2.2(d).	**Corrected**

3	**The Plan had not established standards to ensure that:** • **contracting or plan-operated hospital and emergency health care services are within 30 minutes or 15 miles of all enrollees' residences or workplaces; and** • **ancillary, laboratory, pharmacy, and similar services and goods are available within reasonable distance from the primary care provider.** Rule 1300.67.2.1(f); Rules 1300.51(d)(H)(ii) and (iv).	**Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Medical Survey of a Plan that covers eight major areas of the Plan's health care delivery system[2]. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

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

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.

Prescription Drugs – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.

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

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

[2] The Department conducted a Routine Medical Survey of the Plan's Utilization Management Program supplemental to this survey. The Follow-Up Report can be located at http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/055fs051214.pdf

The Preliminary Report was issued to the Plan on May 1, 2013. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Medical Survey of the Plan, which commenced on June 20, 2012 and closed on March 14, 2013.

PLAN BACKGROUND

Kaiser Permanente began in the 1930s and offers a comprehensive health care delivery system. Kaiser Foundation Health Plan, Inc. obtained its Knox-Keene license in November 1977. Although the Plan has one license, its operations are divided into two distinct regions, Northern and Southern California. In each region, the Plan contracts with Medical Centers and Medical Groups to provide health care professional services to over 6.8 million California members. The Plan relies on the medical centers' and Medical Group's quality review programs to identify and resolve problems with the local medical centers.

Northern California

Kaiser Permanente Northern California ("Kaiser North") consists of three separate legal entities: (1) Kaiser Foundation Health Plan, Inc.; (2) Kaiser Foundation Hospital ("Medical Center"), which includes 17 Medical Centers and 21 hospitals (four Medical Centers have a multi-campus license); and (3) The Permanente Medical Group ("TPMG"), a for-profit multi-specialty Physician corporation. Each entity has an independent Board of Directors.

Southern California

Kaiser Permanente Southern California ("Kaiser South") is also comprised of three separate legal entities: (1) Kaiser Foundation Health Plan, Inc.; (2) Kaiser Foundation Hospital, which includes 14 Medical Centers; and (3) Southern California Permanente Medical Group ("SCMPG"), a for-profit multi-specialty Physician partnership. Each entity has an independent Board of Directors. The Plan contracts with the medical centers and Medical Groups to provide medical and other health care professional services to its enrollees.

The more densely populated Southern California region is divided into the following sub-regions: the Coachella Valley, Kern County, Orange County, the Valleys, Western Ventura County, Inland Empire, Metropolitan Los Angeles/West Los Angeles, San Diego County, and the Tri-Central sub-regions**.** According to information submitted by Kaiser on March 11 in response to the Behavioral Health Final Report, the sub-areas include Antelope Valley, Baldwin Park, Downey, Fontana, Kern County, Los Angeles, Orange County, Panorama City, Riverside, San Diego, South Bay, West Los Angeles, and Woodland Hills.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On May 1, 2013, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

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

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

GRIEVANCES AND APPEALS

Deficiency #1: The Plan did not maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification where appropriate.

Statutory/Regulatory Reference(s): Section 1368(a).

Assessment: Health Plans are required to adequately consider enrollee grievances and rectify the problem raised by the grievance when appropriate. The grievance system is important not only for the individual enrollee involved, but also as a mechanism for the Plan to identify and correct systemic issues. An in-depth review of a random sample of 160 grievance files revealed that the Plan did not adequately identify, consider, and rectify the issues raised in 22 files. While the Department found that the Plan generally complied with the requirements regarding the content and timing of grievance response letters under Section 1368, the files identified by the Department, many with multiple or difficult issues, reflect a failure to adequately consider and resolve grievances. Based on these examples, the Department concluded that the Plan could not demonstrate compliance with its obligation to maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification where appropriate. The specific findings include:

- The Plan failed to screen for and identify urgent matters that required immediate action.
- The Plan failed to identify, analyze and resolve issues in grievances, especially where multiple issues were raised in one grievance.
- The Plan failed to follow-up when critical information was not received or was incomplete in response to its internal inquiries.
- The Plan could not demonstrate that it consistently addressed and documented post-closure correspondence from the enrollee or internal Plan staff to the grievance file.

The following grievances represent examples of the findings:

- An enrollee called the Plan one day after he was involved in a car accident. The enrollee reported that his primary care provider (PCP) was not available and that he was having major neck pain, lingering headaches and blackouts (concussion symptoms) and was requesting an MRI. It appears the grievance was handled as a request for an MRI only and there was no evidence that the Plan advised the enrollee to seek urgent medical attention if he was having symptoms of a concussion and/or severe pain. The Plan's resolution of the complaint included a denial of the enrollee's request for an MRI and a recommendation that he see his PCP. The Plan did not address the enrollee's assertion that his PCP was unavailable.

- An enrollee filed a grievance alleging that the Plan had made a mistake regarding the first date of individual enrollment for her newborn baby. She asserted that her newborn was entitled to coverage under her group plan until April 1, and only then should have been enrolled in an individual plan. The Plan response advised the enrollee that if she wanted coverage to have started on April 1, she should contact Member Services. This response appears to ignore the fact that the enrollee had already filed a grievance with Member Services. The Plan's response failed to address the enrollee's allegations. In order to resolve the issues in the case adequately, at a minimum, the Plan should have explained what type of coverage the mother and newborn had, why it ended on March 1 and why the child's individual enrollment started on March 1. In addition to these concerns, it appears the Plan may have retroactively terminated this enrollee for nonpayment.

- An enrollee filed three separate complaints on May 23. The first involved a lengthy wait time in the urgent care clinic on April 18. The second involved the lack of care and service by a Physician's Assistant in the Emergency Department on May 18. The third related to poor customer service by an appointment center representative on April 19. The grievance case manager sent three separate internal inquiries to the relevant managers/supervisors. Only one of the inquiries received a response. The Plan closed the grievance without the other two responses being received.

- An enrollee complained that she was having an access to care issue because there was only one of a certain type of provider in the Plan's facility. An internal inquiry was sent to the facility, which did not appear to address the issue of staffing. Additionally, the Plan's screening for quality of care referrals used the appointment the enrollee received *after* she filed a grievance as evidence that there was no quality or access problem.

- An advocate for an enrollee with significant behavioral health history (including past care through various treatment modalities and recent treatment in a Plan facility) presented a multi-issue grievance, reporting that the enrollee was experiencing constant migraine headaches, memory loss, blurred vision, and mental confusion. Despite these very serious clinical symptoms, the grievance case manager never addressed the request for immediate care, characterizing the matter as involving nothing beyond "a quality of care case and grievance for reimbursement for all services…"

Despite follow-up contact with Member Services eleven days later (during which the representative reported that the enrollee was in “excruciating pain” and noted that the treating Physician was not willing to prescribe additional medication), the results from an internal Physician review conducted by the Plan (and recommending that the enrollee be immediately evaluated by a neurologist) were never shared. The enrollee was instead told to seek services at an emergency room or present for treatment at another facility, and the grievance resolution letter did not address the urgent clinical issues or the request for immediate out-of-plan treatment, framing the matter as a reimbursement case and then quoting three and one-half pages of the enrollee’s Evidence of Coverage in support of the Plan's denial of the copayment reimbursement issues.

The Department later discovered that there were at least forty (40) post-closure email messages between the enrollee and the Plan that complained about the manner in which the grievance was handled and continued to request assignment of a Case Manager to coordinate care. The Plan failed to initiate a new grievance until the matter was brought to its attention by the DMHC.

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

Plan’s Compliance Effort: The Plan responded that it would develop and implement additional mandatory training for all Member Services staff to improve staff knowledge of grievance process requirements relating to the four findings cited by the Department. The Plan has completed individual coaching and counseling to each case processor with deficiencies identified. The Plan stated that by the third quarter of 2013 it would establish improved processes for responses to investigative inquiries and issue follow-up (e.g., a process for Member Service staff to connect directly with designated clinical or service individuals and health plan administration to arrange for responses to investigative inquiries and to address the member’s issues). The Plan will also improve processes for holistic review, improve the content of resolution letters sent to members, and institute Member Services Critical Case Teams within the Member Case Resolution Centers to address cases with medical necessity issues and/or multiple complex issues. Finally, the Plan stated it would conduct a baseline audit of the areas of identified deficiencies in July 2013 with a follow-up validation audit in the following quarter.

Department’s Finding Concerning Plan’s Compliance Effort: The Department found that the Plan designed and implemented a corrective action plan. The Plan provided the Department information demonstrating it has fully established Member Services Critical Care Teams, completed training of all staff, established a process through which Member Services can connect directly with clinical staff to assist in addressing member issues, and implemented an ongoing audit and re-training program to maintain a grievance system that ensures adequate consideration of enrollee grievances and rectification where appropriate.

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan corrected the deficiency.

ACCESS AND AVAILABILTY OF SERVICES

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

Statutory/Regulatory Reference(s): Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(5); Rule 1300.67.2.2(d).

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

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

The regulatory standard for non-urgent appointments with a specialist is 15 business days (or 21 calendar days, as filed by the Plan). If the Average Days Wait for this appointment type equals 21 calendar days or less, the Plan reports the service area as compliant with this standard.

The Department found that, in practice, the Plan's methodology for calculating compliance hinders the Plan's ability to detect patterns of non-compliant wait times and leads to incomplete compliance reports. By averaging the number of days waited for each appointment, the Plan's methodology offsets a pattern of long wait times with shorter wait times. Using only an average of all wait times does not present a complete analysis of trends or patterns of non-compliant wait times. In practice, a number of the medical centers' monthly wait times appeared to be compliant (i.e., had an average of 21 calendar days or less) even though a significant proportion of their appointments were one or more days over the standard.

For example, in this survey of the Plan's medical services (excluding behavioral health), the Department found that significant proportions of individual appointments exceeded the standards.[3] The Department did note, however, that the proportions of cases

[3] The Department conducted a Routine Medical Survey of the Plan's Behavioral Health operations in 2012, and cited a similar deficiency based on the Plan's use of the same methodology to report compliance with appointment wait time standards for mental health services. See the Department's *Final Report, Routine Medical Survey of Kaiser Foundation Health Plan, Inc., Behavioral Health Services*, issued to the Plan on March 6, 2013.

exceeding standards were generally smaller in the various medical departments (e.g., neurology, OB/GYN, ophthalmology) than they had been in the Plan's behavioral health department.

Rule 1300.67.2.2(c)(1) requires plans to provide or arrange for health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Rule 1300.67.2.2(c)(5) further requires each plan to ensure that its providers offer enrollees appointments that meet specified timeframes with some exceptions permitted (e.g., preventive care services).

Rule 1300.67.2.2(d) requires the Plan's Quality Assurance Program to establish compliance monitoring policies and procedures that are designed to accurately measure the accessibility and availability of contracted providers, and to track and document network capacity and availability with respect to the time elapsed appointment standards. The Plan's reporting methodology does not provide a complete and accurate assessment of the Plan's compliance to appointment standards. By providing an overall determination of compliance based on averaging the days waited for each appointment, the Plan does not account for individual appointments with excessive days waited (as those appointments are offset by appointments with shorter wait times). Therefore, the Plan's monitoring policies and procedures do not accurately measure the accessibility, and availability of contracted providers with respect to the time elapsed appointment standards as required by Rule 1300.67.2.2(d). In addition, without accounting for individual appointments with excessive wait times, the Plan cannot ensure that the Plan's provider network is sufficient to provide accessibility, availability, and continuity of care as required by the Knox-Keene Act.

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

Plan's Compliance Effort: In response to this deficiency, the Plan implemented the following:

1) New Measurement Methodology: The Plan adopted a measure for tracking access to appointments – "Percentage Initiated to Seen." It measures, by department and facility, the percentage of initial appointments that had wait times within the timeframe applicable for each appointment type. This new measure differs from Average Days Wait because it shows the *percentage* of appointments where the wait time was within the applicable period, rather than an *average* of all of the waits. The Plan will use this new measure in addition to its three existing measures: member complaints, provider surveys, and Average Days Wait.

2) New Committees: The Plan has formed new committees dedicated to access and availability in each region. The Northern California Access Committee is a sub-committee of the Quality Oversight Committee and was formed in July 2012. The Southern California Access Sub-Committee is a sub-committee of the Member Concerns Committee, which reports to the Southern California Quality

Committee and was formed in August 2012. The Plan provided a copy of the sub-committees' charter for the Department's review.

3) Monitoring of Access and Availability: As a result of the changes above, three reports will be reviewed by each of the Access Committees to monitor access and availability;
    - Percentage Initiated to Seen for initial appointments by timely access regulatory category reviewed monthly.
    - Ratio of Providers to Members, reviewed bi-annually.
    - Average Days Wait for initial appointments by timely access regulatory category, reviewed monthly.

The Northern California Access Committee began reviewing the Average Days Wait Report in September 2012 and the Ratio of Providers to Members in November 2012. In January 2013, the Northern California Access Committee began reviewing a Percentage Initiated to Seen Report that shows trended access data for urgent and initial non-urgent appointments. The Southern California Access Sub-Committee began reviewing performance and action plans based on Average Days Wait in August 2012, and Percentage Initiated to Seen data in December 2012.

4) Oversight: Regional oversight occurs as the Northern California Access Committee and the Southern California Access Sub-Committee report on access to their respective regional Quality Committee on a quarterly basis (or more frequently if warranted). The Plan updated Regional Quality Program Descriptions and Work Plans to include the activities of the new access committees in Northern California April 2013 and in Southern California in May 2013.

5) Amendment: The Plan also filed an Amendment with the Division of Licensing regarding its new methodology for measuring and tracking access.

Department's Finding Concerning Plan's Compliance Effort: The Department found that the Plan has designed and implemented a new reporting measure, "Percentage Initiated to Seen", that appropriately measures compliance with wait time standards. The Plan has filed its appropriate and improved methodology through an amendment, which the Department has accepted and has initiated reporting under the new methodology. The Plan has also implemented new committees to improve oversight and facilitate prompt response to access concerns.

As noted above under the *Assessment s*ection**,** the Plan's previous methodology for reporting compliance did not present a complete picture of wait times; it offset long wait times with shorter wait times, allowing monthly wait times at a number of the medical centers to be reported as compliant even though a significant proportion of their appointments were over the standard. The flawed data hindered the Department from making a full assessment of Plan performance during the initial survey visit. Given that the new measure now provides a more useful picture of wait times, the Department revisited the Plan for a one-day onsite assessment in the Plan's Northern Region and another in the Southern Region to review the resulting data from January 2013 forward.

The Department also assessed the Plan's use of the data for ongoing monitoring and its implementation of corrective actions where problems were identified.

In the Northern Region, the Department found that the Access Committee meets monthly. It receives and reviews reports of percentage of appointments initiated to seen displayed at the medical center level as well as broken out by individual specialty department (Allergy, Dermatology, Neurology, Orthopedics, Primary Care, etc.). The committee also reviews related data such as average days wait, provider-to-member ratios, enrollee and provider satisfaction survey results, and access-related grievances. These reports feed up to the Quality Oversight Committee along with Access Committee minutes for further oversight. Similar reports are provided on a more frequent basis (e.g., weekly) to medical center Physician Leaders and administrators. If any Department is out of compliance (below 80%[4]) for one month, the committee contacts the Department Leaders for details, and to assess corrective actions. If the concern cannot be immediately corrected, the Physician-in-Chief and area Manager must attend the next Access Committee meeting and present a corrective action plan.

The Department's review of the reports found that any downward trends in compliance rates are being detected and addressed promptly and that interventions have been effective. From among all departments at all 14 medical centers, four full-service departments showed compliance below 80% early in the year. In two cases, compliance was above 80% by the following month. One required two months and the fourth was out of compliance for three months, showed improvement, but dipped again for two months. All departments were compliant in the latter months of the year.

In the Southern Region, the Department found that the Access Sub-Committee, which meets most months, regularly reviews reports on percent of appointments booked within standard, appointment volume, staffing levels, grievance rates, satisfaction surveys, etc. The key report displays the new compliance measure rates for each of the 13 medical centers and for the region by specialty department. Each of the approximately 375 medical center-by-department cells in the report is color-coded to indicate level of compliance. If the department was compliant for all three of the most recent months it is coded green; if non-compliant for one or two months it is yellow; if it is non-compliant for all three months it is red. Arrows are added to indicate whether a medical center has been trending up or down. The report shows significant improvements in access over the past year. In the February 2013 report, 37 cells were coded red and over 70 were yellow. The most recent report ending November 2013 showed five cells coded red and 47 yellow. Corrective actions have been initiated at each, and progress is being monitored.

The sub-committee requires corrective action plans for any medical centers with departments outside of compliance. The status/effectiveness of each action plan for each medical center is tracked at each meeting (as well as being reviewed outside this

[4] The Percentage Initiated-to-Seen measure tracks time from the request for an appointment to the time the member is actually seen (rather than the date/time of the first available appointment). The regulation sets standards for a plan to make appointments *available*; however, members making appointments may at their discretion reject the first available appointment in favor of a later, more convenient date/time. Recognizing that patient choice may result in some appointments exceeding the timeframe, the Plan has set its threshold for action at 80%.

committee daily/weekly by department staff, medical centers, and Plan/SCPMG management). Corrective action planning and progress reporting are very detailed (e.g., number of new appointments expected for each new hire/added day of staff time). Actions include hiring staff, working additional hours/days, extended clinic hours, borrowing of staff from other Plan medical centers, overbooking where cancellations are a problem, correction of booking category errors, use of registry providers, and use of contracted providers. The number of medical center departments on corrective action plans has steadily decreased as the number meeting access requirements has increased. Minutes indicate that significant problems, or problems not resolved in a reasonable time, are escalated to the Plan/Regional Health Plan Officers.

In both regions, then, the Plan has implemented useful reporting, increased intensity/timeliness of oversight through the new access committees, and demonstrated prompt implementation of effective corrective actions when concerns are noted. As a result, full service appointment availability has improved significantly in both regions. There remain individual departments at some medical centers that have not yet achieved compliance or have not yet maintained compliance for a period of three months. These have appropriately been placed on corrective action plans and are being monitored to track progress.

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency. The Department will continue to monitor the Plan's ongoing use of the data and its prompt implementation of corrective actions in response to any non-compliance.

Deficiency #3: The Plan had not established standards to ensure that:

- **contracting or plan-operated hospital and emergency health care services are within 30 minutes or 15 miles of all enrollees' residences or workplaces; and**
- **ancillary, laboratory, pharmacy and similar services and goods are available within reasonable distance from the primary care provider.**

Statutory/Regulatory Reference(s): Rule 1300.67.2.1(f); Rules 1300.51(d)(H)(ii) and (iv).

Assessment: The Department's review of Plan policies and procedures for the Southern California service area regarding access to services revealed that the Plan has not established specific standards for geographic access to hospitals, emergency health care services, and ancillary services. During interviews, the survey team learned that the Plan had discovered while preparing for the survey that it did not have these standards. Plan staff noted, however, that they regularly assess distance and drive times for Plan facilities. The Plan had developed a draft policy containing such standards, and at the time of the onsite survey, was in the process of sending the policy

through appropriate committees for review and approval. The survey team did not review this new policy while onsite.

Rule 1300.51(d)(H)(ii) requires plans to ensure that all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services. Rule 1300.51(d)(H)(iv) requires that ancillary laboratory, pharmacy and similar services and goods be available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider. Rule 1300.67.2.1(f) requires each plan to have a documented system for monitoring and evaluating accessibility of care. Because the Plan has not established standards against which to monitor, measure, and evaluate its compliance with these requirements, and has not documented those standards in a policy, the Department finds the Plan not in compliance with the regulations.

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

Plan's Compliance Effort: The Plan's Southern California Quality Committee reviewed and approved a newly created policy that sets forth the requirements of Rule 1300.51(d)(H)(ii) regarding hospitals/emergency rooms within 30 minutes or 15 miles of members' residence or workplace and Rule 1300.51(d)(H)(iv) regarding ancillary services within a reasonable distance from the primary care provider. The Plan provided a copy of this policy, Availability Standards of Hospitals, Facilities, and Ancillary Services Policy (signature date 5/24/13), as evidence of compliance.

Department's Finding Concerning Plan's Compliance Effort: The Department finds that the Plan has developed a new policy that includes the following standards as required by Rule 1300.67.2.1(f) and Rules 1300.51(d)(H)(ii) and (iv):

- Members shall have a residence or work within 15 miles or 30 minutes of a Plan owned and operated or contracted Plan Hospital with an emergency department.
- The geographic distribution or driving time to ancillary services provided by contracted or plan-operated providers shall be provided either on the same facility campus, or within a reasonable distance from the member's primary care provider.

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan has fully corrected this deficiency.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Medical Survey.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**

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

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2012 Routine Medical Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.