DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

DBA: KAISER PERMANENTE

A FULL SERVICE HEALTH PLAN

MAY 2, 2024

Routine Survey Follow-Up Report
Kaiser Foundation Health Plan, Inc.
DBA: Kaiser Permanente
A Full Service Health Plan

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EXECUTIVE SUMMARY

In the Final Report for the Routine Survey (Final Report) of Kaiser Foundation Health Plan, Inc. dba Kaiser Permanente (Plan), dated February 11, 2021, the California Department of Managed Health Care (Department) identified seven uncorrected deficiencies. The Plan was advised the Department would conduct a follow-up review (Follow-Up Survey) to assess the status of the seven outstanding deficiencies and issue a report within 18 months of the date of the Final Report.[1]

The survey team conducted the Follow-Up Survey pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), codified at Health and Safety Code section 1340 *et seq*., and Title 28 of the California Code of Regulations section 1000 *et seq*.[2] On November 8, 2021, the Department notified the Plan of its scheduled Follow-Up Survey and requested the Plan submit information regarding its uncorrected deficiencies as cited in the Final Report.

The Follow-Up Survey addressed outstanding deficiencies in the following areas:

Quality Assurance
Grievances and Appeals
Utilization Management
Prescription (Rx) Drug Coverage

The Follow-Up Survey revealed five of the previous seven outstanding deficiencies remained uncorrected.

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON FEBRUARY 11, 2021	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	QUALITY ASSURANCE	
1	**The Plan fails to ensure that the quality of care provided is reviewed, problems are identified and effective action is taken to improve care where deficiencies are identified. (Statewide)** Rule 1300.70(a)(1), (b)(1)(B).	**Not Corrected**

[1] 2019 Kaiser Foundation Health Plan, Inc. Final Report
[2] All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

	GRIEVANCES AND APPEALS	
2	**The Plan's grievance system does not consistently monitor whether grievances are resolved in favor of the enrollee or the Plan. (Statewide)** Section 1368(a)(1); Rule 1300.68(e)(1).	**Corrected**
3	**The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate. (Statewide)** Section 1368(a)(1); Rule 1300.68(a)(1).	**Not Corrected**
4	**For grievances involving delay, denial or modification of health care services, the Plan's response does not describe the criteria used and clinical reasons for the decision related to medical necessity. (Statewide)** Section 1368(a)(5); Rule 1300.68(d)(4).	**Not Corrected**
	UTILIZATION MANAGEMENT	
5	**The Plan does not systematically and routinely analyze utilization data to monitor potential over- and under-utilization of services. (Statewide)** Rule 1300.70(a)(3), (c).	**Not Corrected**
6	**The Plan failed to demonstrate it complies with post-stabilization care requirements. (Northern California)** Section 1262.8(f)(1); Section 1371.4(b), (d), (j)(1), (j)(2)(B)-(C), (j)(3); Section 1386(b)(1); Rule 1300.71.4(a), (b)(1)-(3), (d).	**Not Corrected**
	PRESCRIPTION (RX) DRUG COVERAGE	
7	**The Plan does not update its formulary on a monthly basis. (Statewide)** Section 1367.205(a)(1)-(3).	**Corrected**

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

The following details the Department's findings regarding the outstanding deficiencies. The Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health and Safety Code section 1380(i).

DEFICIENCIES

QUALITY ASSURANCE

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

Regulatory References: Rule 1300.70(a)(1), (b)(1)(B).

Plan's Follow-Up Compliance Effort: In response to the Department's notice to conduct the Follow-Up Survey, the Plan stated it:

- Conducted multiple trainings for front-line staff and nurse consultants.
- Enhanced clinical review and documentation of potential quality of care concerns in all cases, including those not involving direct patient care, to identify those that may have care or safety gaps.
- Revised the Non-Clinical Screening Criteria.
- Performed regular audits of cases closed from Quarter 4 2020 through Quarter 3 2021 against a 95 percent compliance rate to validate the effectiveness of these corrective action plans.

Supporting Documentation:

- DEF1_1 Narrative Description (December 9, 2021)
- DEF1_3 Non-Clinical Quality of Care Coding Criteria
- California Non-Medicare Grievance and Appeals (July 23, 2021)
- Non-Clinical Quality of Care Coding Criteria for Medicare and Non-Medicare Process Levels (July 23, 2021)
- Clinical Consultants Screening Criteria (Complaints Referred to the Quality Department) (January 1, 2017)
- Deficiency 1.1 PQI Referral Audit Tool (Quarter 4 2020 through Quarter 3 2021)
- Validation Audit Results for Deficiency 1.2 (Quarter 4 2020, Quarter 2 2021, Quarter 3 2021)
- 66 Exempt Grievance Batch A Files (August 1, 2021 through October 31, 2021)[3]
- 69 Exempt Grievance Batch B Files (August 1, 2021 through October 31, 2021)[4]

[3] Exempt Grievance Batch A Files consists of exempt grievances the Plan categorized as "Access."
[4] Exempt Grievance Batch B Files consists of exempt grievances the Plan did not categorize as "Access."

- 71 Standard Grievance Batch B Files (August 1, 2021 through October 31, 2021)[5]
- 61 Expedited Grievance Files (August 1, 2021 through October 31, 2021)

Follow-Up Survey Assessment: The Plan's grievance and appeal policy describes the Plan's procedures for receipt and handling of enrollee grievances. The policy states, "Potential Quality of Care Issues: Grievances that contain one or more potential quality of care issue(s) will be referred to the Quality Department for investigation and review."[6] As noted in and unchanged from the Final Report, the Plan's process for identifying potential quality issues (PQIs) is to have Program Representatives[7] create an electronic case file for each call, documenting all relevant information. The policy states:

> Program Representatives use Non-Clinical Screening Criteria to determine which issues require referral and those that meet criteria are sent to the Member Relations Clinical Consultants[8] to ensure a clinical review is conducted. Clinical Consultants review these issues, including any pertinent documents, records, or systems and utilize Clinical Screening Criteria to determine if referral to the Quality Department is appropriate.[9]

The Plan submitted four quarters of audit results in which standard and exempt grievance files were assessed to determine whether Program Representatives appropriately identified PQIs in accordance with the Non-Clinical Screening Criteria.[10] The compliance goal was 95 percent. Compliance rates are as follows:

Program Representative Compliance with PQI Identification

Grievance Type	Q4 2020	Q1 2021	Q2 2021	Q3 2021
Standard	77%	80%	89%	91%
Exempt	97%	100%	100%	100%

The Plan also submitted three quarters of audit results in which the Plan reviewed expedited grievance files to assess whether the Clinical Consultant's "decision not to refer [PQIs] to the Quality Department is consistent with the Clinical Screening Criteria."[11] The compliance goal was 95 percent. Compliance rates are as follows:

[5] Standard Grievance Batch B Files consists of standard grievances categorized by the Plan as "Access," "Allegation of Abuse/Harm," "Attitude/Service," "Compliance Related," "Facility/Environment," "Quality of Care," or "Quality of Service"; not categorized as "Denied" or "Partial"; and not "Referred to Quality."
[6] California Non-Medicare Grievance and Appeals, page 29.
[7] Program Representatives are the Plan's member services employees who receive telephone calls from enrollees.
[8] Clinical Consultants, or Member Services Clinical Consultants, are registered nurses employed by the Plan to review complaints for PQIs and refer the complaints to the Plan's quality department when appropriate.
[9] California Non-Medicare Grievance and Appeals, page 29.
[10] Deficiency 1.1 PQI Referral Audit Tool
[11] Validation Audit Results for Deficiency 1.2

Clinical Nurse Consultant Compliance with Forwarding Quality Issues

Grievance Type	Q4 2020	Q1 2021	Q2 2021	Q3 2021
Expedited	100%	No data provided	93%	100%

The Plan's first set of audits showed Program Representatives did not appropriately identify PQIs in standard grievance files (four out of four quarters). However, the Plan's audits showed Program Representatives appropriately identified PQIs in exempt grievance files (four out of four quarters). It is unknown what actions the Plan took to ensure Program Representatives meet compliance goals. The Plan's second set of audits showed Clinical Consultants met compliance goals in two out of four quarters. It is unknown why no data was provided for Quarter 1 2021.

After review of the Plan's standard, exempt, and expedited grievance files, the Department determined:

- The Plan's Program Representatives failed to consistently identify PQIs requiring referral to Clinical Consultants; and
- The Plan's Clinical Consultants failed to consistently refer all quality issues to the Plan's quality department for review, investigation, leveling and corrective action, as necessary.

a. The Plan's Program Representatives fail to consistently identify PQIs requiring referral to Clinical Consultants.

The Department reviewed 71 randomly selected standard grievance files (Batch B). Of these, 49 files included PQIs.[12] Of these 49 files, 19 files (39%)[13] did not include evidence the Program Representative forwarded the grievance to the Clinical Consultant for review.

The Department reviewed 66 randomly selected exempt grievance files (Batch A). Of these, 24 files included PQIs.[14] Of these 24 files, none included evidence the Program Representative forwarded the grievance to the Clinical Consultant for review.

The Department reviewed 69 randomly selected exempt grievance files (Batch B). Of these, 22 files included PQIs.[15] Of these 22 files, 19 files (86%)[16] did not include evidence the Program Representative forwarded the grievance to the Clinical Consultant for review.

[12] DMHC Standard Grievance Batch B Files: 4-8, 10-11, 13-16, 18-19, 21-29, 31-35, 37-41, 44-48, 51-53, 55, 57-58, 61-62, 66, 68, 70, 72-73
[13] DMHC Standard Grievance Batch B Files: 5-7, 14, 16, 22, 25-26, 28, 31, 37-38, 40, 46, 52, 55, 61, 66, 70
[14] DMHC Exempt Grievance Batch A Files: 1, 3, 5-8, 11, 17, 21-22, 25-26, 29, 33, 36-41, 43, 50, 59, 63
[15] DMHC Exempt Grievance Batch B Files: 5, 7-8, 13, 16, 23, 27, 32, 35, 42, 49-51, 56, 59-60, 62, 64-65, 70-72
[16] DMHC Exempt Grievance Batch B Files: 5, 7-8, 13, 16, 23, 27, 32, 35, 42, 49-51, 56, 60, 62, 64-65, 70

The Department reviewed 61 randomly selected expedited grievance files. Of these, 36 files included PQIs.[17] Of these 36 files, six files (17%)[18] did not include evidence the Program Representative forwarded the grievance to the Clinical Consultant for review.

Case Examples

- **Standard Grievance Batch B File #5:** The enrollee's mother complained about special-order prescription eye drops that took over a month to receive. Despite being a 30-day supply, the prescription expired two weeks after it was filled. The medication was used for a week before the mother noticed the medication had expired. The enrollee had to fill a second prescription and pay a second copayment. The grievance requested reimbursement for both copayments and a new, non-expired prescription.

  Based on the Plan's Non-Clinical Screening Criteria, this complaint involves an allegation of prescription error or dispensing error.[19] The enrollee's mother was allegedly not made aware of the two-week expiration of the medication. There is potential for enrollee harm with the use of an expired medication, either from an adverse reaction or decreased clinical efficacy of the medication, leading to delayed treatment of the enrollee's condition. Because the member services representative failed to identify the PQI in this grievance, it was not forwarded to a clinical consultant for review, and the file is therefore deficient.

- **Exempt Grievance Batch A File #3:** The enrollee called to request an earlier appointment with the Obstetrics and Gynecology Department. The enrollee stated she was pregnant and had a previous miscarriage at six weeks. Additionally, the enrollee described a previous provider as being "awful." She also complained about the appointment scheduling process and requested to be seen out-of-Plan if an earlier appointment could not be provided.

  The Department reviewed the audio file for this grievance. The enrollee stated she is pregnant and unhappy with her prenatal care. The enrollee became tearful during the call and stated, "I had one doctor, a practitioner that was awful," and said she avoided seeing this practitioner. The enrollee also stated, "They don't have anything until week 11. I had a miscarriage at week six last time, so I don't want to wait until week 11."

  The Program Representative failed to recognize two PQIs in this grievance. The first is the enrollee's allegation the provider was "awful." The Program Representative asked no clarifying questions to assess why the enrollee had this opinion. This could have fallen into several categories within the Non-Clinical Screening Criteria, but because the Program Representative did not ask additional questions, the exact nature of this PQI cannot be determined.

[17] DMHC Expedited Grievance Files: 1-4, 7-9, 11-12, 15, 18, 20-26, 28, 30, 33-34, 36, 40-41, 45-46, 48-54, 57-58
[18] DMHC Expedited Grievance Files: 2-3, 20-21, 45-46
[19] Non-Clinical Quality of Care Coding Criteria for Medicare & Non-Medicare Process Levels, page 6.

The second issue is the delayed access to an initial Obstetrics and Gynecology appointment. Based on the Plan's Non-Clinical Screening Criteria, this complaint involves an allegation of inadequate access to care.[20] The enrollee has a legitimate concern this delay will impact her pregnancy as she experienced a previous miscarriage. Because the Program Representative failed to identify the PQI in this grievance, it was not forwarded to a clinical consultant for review, and the file is therefore deficient.

- **Exempt Grievance Batch B File #32:** The enrollee placed her pharmacy order on kp.org and was required to provide a credit card to finalize the order. The enrollee expressed concerns as to why she was asked for a credit card when the prescription requires no copayment. The enrollee received a call from the pharmacy to advise her prescription was pending payment. The enrollee was frustrated regarding the incorrect cost of the prescription. Subsequent documentation revealed the prescription was insulin, a critical medication for a patient with diabetes mellitus.

  Based on the Plan's Non-Clinical Screening Criteria, this complaint involves an allegation of inadequate access to care.[21] The criteria provides, "Inadequate access can consist of cancellation/delay in obtaining any of the following: Prescriptions."[22] A delay in obtaining a prescription medication, either due to system processes, provider access, or the enrollee being asked for a copayment that the enrollee may not be able to pay, is an issue with the potential for enrollee harm. The enrollee did not need to specifically allege the delay would impact her health, as a delay in receiving an insulin prescription will always have the potential to impact the enrollee's health. Because the Program Representative failed to identify the PQI in this grievance, it was not forwarded to a clinical consultant for review, and the file is therefore deficient.

Based on the above, the Department has determined the Plan's Program Representatives fail to consistently identify PQIs requiring referral to Clinical Consultants.

b. The Plan's Clinical Consultants fail to consistently refer all quality issues to the Plan's quality department for review, investigation, leveling and corrective action, as necessary.

Based on review of the Plan's expedited grievance files, the Department determined the Plan's Clinical Consultants do not refer all quality issues to the Plan's quality department. Clinical Consultants continue to evaluate enrollees' medical records to determine whether any actual harm occurred, instead of reviewing the quality of care issues and whether that issue itself represents a potential for harm to either that enrollee, or other enrollees who may experience a similar issue.

In some cases, the Clinical Consultants continue to document the care decision was a matter of clinical judgment for the treating provider to make and do not consider whether

[20] Non-Clinical Quality of Care Coding Criteria for Medicare & Non-Medicare Process Levels, pages 2-3.
[21] *Id*.
[22] *Id*., page 3.

the care itself posed PQIs. As described above in "part a," 30 out of 36 expedited grievances with PQIs were appropriately referred to the Clinical Consultant for review. The remaining six files are deficient because the Program Representative failed to recognize the PQI and forward the case to the Clinical Consultant. Of the 30 files forwarded to the Clinical Consultant, the Department found 12 files (40%)[23] were not appropriately referred to the quality department.

Case Examples

- **Expedited Grievance File #4:** This case involves allegations of mismanagement of care resulting in post-operative complications from the enrollee's gallbladder procedure. The enrollee had an inflamed gallbladder and was "treated with placement of percutaneous drain." Prior to discharge, the enrollee was diagnosed with an "elevated white count" which was "normalized prior to discharge." The file stated, "The care provided did not appear to present any safety or care gaps; therefore, does not meet clinical criteria for referral to Quality based on the available documentation."

  The case was appropriately forwarded by the Program Representative to the Clinical Consultant (a registered nurse) because of the allegation of "mismanagement of care." The Expedited Review Unit (ERU) evaluated only the request for an out of Plan referral. There was no evidence the case was reviewed by a section chief to evaluate the "mismanagement of care" claim. The Clinical Consultant did not refer the case to quality review, but instead, documented the Clinical Consultant's assessment of the case.

  The Clinical Consultant's review of the quality of care for a surgical procedure is beyond the scope of practice for a registered nurse. While registered nurses are qualified to assist in PQI investigation, the actual determination of whether the surgical procedure to place the percutaneous drain represented a PQI is a decision for a licensed physician. The Clinical Consultant appears to have evaluated the case on the actual outcome upon discharge for the enrollee. The Clinical Consultant's failure to refer this case resulted in no physician review of the quality of the enrollee's care and whether the care delivered represented a potential for enrollee harm.

- **Expedited Grievance File #12:** This case involves an enrollee who "was not happy with the original surgeon he saw" and requested a "second opinion from an outside (Non KP) provider."

  The case was appropriately forwarded by the Program Representative to the Clinical Consultant because of the enrollee's expression of dissatisfaction with the original surgeon. The ERU reviewed the case, but only regarding the request for the out of Plan referral, which was denied as not a covered benefit. There was no evidence the case was reviewed by a section chief to evaluate the enrollee's documented expression of "not happy with the original surgeon he saw."

[23] DMHC Expedited Grievance Files: 1, 4, 11-12, 15, 18, 22-23, 25, 33, 51, 57

The Clinical Consultant's review of the quality of care did not include an investigation into the enrollee's expression of dissatisfaction with the "original surgeon." There is no documentation a Plan nurse or physician investigated the enrollee's expression of dissatisfaction with the surgical consultation. The Clinical Consultant's failure to refer this case resulted in no review of the quality of the enrollee's care for the surgical evaluation, and whether the care delivered represented a potential for enrollee harm.

Based on the above, the Department has determined the Plan's Clinical Consultants do not consistently refer all quality issues to the Plan's quality department for review, investigation, leveling and corrective action, as necessary.

TABLE 1
Standard, Exempt, and Expedited Grievance File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievance containing PQI (Batch B)	49	Review quality of care and identify quality of care issues	30 (61%)	19 (39%)
Exempt Grievance containing PQI (Batch A)	24	Review quality of care and identify quality of care issues	0 (0%)	24 (100%)
Exempt Grievance containing PQI (Batch B)	22	Review quality of care and identify quality of care issues	3 (14%)	19 (86%)
Expedited Grievance containing PQI	36	Review quality of care and identify quality of care issues	30 (83%)	6 (17%)
Expedited Grievance containing PQI	30	Refer potential quality issues to the quality department	18 (60%)	12 (40%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds the Plan has taken steps to address this deficiency by updating its Non-Clinical Screening Criteria to include improved examples of issues that would meet the Plan's criteria, providing training to staff on these updates, and auditing grievance files to assess staff compliance. However, the Department's file review showed Plan Representatives are still failing to identify and refer all PQIs for clinical review.

The Plan also implemented a process to review cases that are forwarded to the Clinical Consultant to assess whether the Clinical Consultant's action was consistent with the Clinical Screening Criteria. However, Clinical Consultants continue to fail to refer incidents for quality of care and quality of service review, as demonstrated by the Department's file review discussed above. The Plan misses the opportunity to assess whether the provider's actual care, service, or failure to provide care, or error in care or service, regardless of the outcome, was a quality issue that required review and correction.

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

GRIEVANCES AND APPEALS

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

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

Plan's Follow-Up Compliance Effort: In response to the Department's notice to conduct the Follow-Up Survey, the Plan stated it implemented enhancements to its Grievance and Appeal tracking system (METRS) to capture the nature of the resolution for each issue identified. The system now contains a dropdown menu with three options:

> 1) in favor of enrollee, 2) partially in favor of enrollee, 3) in favor of the Plan. The system requires Plan representatives to choose one option for each issue identified within a grievance prior to case completion. This system enhancement went live in August 2020 and staff received training in [Quarter 3 2020].

Additionally, beginning with cases closed in Quarter 1 2021, the Plan conducted quarterly internal audits against a 95 percent compliance rate to validate the effectiveness of this corrective action consisting of 30 standard grievances and 30 exempt grievances each quarter. The audit results were as follows:

- Quarter 1 2021 Audit: 100% Compliant
- Quarter 2 2021 Audit: 97% Compliant
- Quarter 3 2021 Audit: 100% Compliant[24]

Supporting Documentation:

- DEF2_1 Narrative Description (December 9, 2021)
- Resolutions for Non-Medicare Process Levels Standard Operating Procedure (September 8, 2021)

[24] Audit Periods: January 7, 2021 through February 28, 2021; March 1, 2021 through May 31, 2021; June 1, 2021 through August 31, 2021.

- LF-02 Statewide Exempt Grievance Log (August 1, 2021 through October 31, 2021)
- LF-03 Statewide Expedited Grievance Log (August 1, 2021 through October 31, 2021)
- LF-04 Statewide Grievance Log (August 1, 2021 through October 31, 2021)

Follow-Up Survey Assessment: The Plan provided the Department with:

1. A list of staff members who completed METRS training.
2. A standard operating procedure "outlin[ing] expectations and standards for processing resolutions once investigation is complete, and all the issues and requests…have been resolved."[25]
3. Exempt, expedited, and standard grievance logs. In each log, there is a column named "Whether resolved in favor of" that contains the three nature of the resolution options.[26]

The Department reviewed the METRS updates and confirmed the three nature of the resolution options described above are now available in the system's drop-down menu.

Follow-Up Report Deficiency Status: Corrected

The Department finds the Plan configured its METRS system to include the ability to document grievance resolutions in favor of the enrollee, partially in favor of the enrollee, or in favor of the Plan. The Plan provided training and job aids for staff to complete this documentation and audited grievance files for compliance.

Based upon the corrective actions undertaken, the Department has determined this deficiency has been corrected.

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

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

Plan's Follow-Up Compliance Effort: In response to the Department's notice to conduct the Follow-Up Survey, the Plan stated it conducted six trainings for customer service representatives "to provide guidance on identifying oral expressions of dissatisfaction as a grievance." The Plan also "conducted quarterly audits…randomly sampled 100 inquiry files to determine whether the cases were properly classified as inquiries." The compliance rate was set at 95 percent. Audit results were as follows:

- Quarter 4 2020 Audit: 93% Compliant

[25] Resolutions for Non-Medicare Process Levels Standard Operating Procedure
[26] Exempt grievance log (Column M), expedited grievance log (Column M), standard grievance log (Column Q).

- Quarter 1 2021 Audit: 96% Compliant
- Quarter 2 2021 Audit: 97% Compliant
- Quarter 3 2021 Audit: 94% Compliant

Supporting Documentation:

- DEF3_1 Narrative Description (December 9, 2021)
- 54 Call Inquiry Files (October 15, 2021 through October 31, 2021)

Follow-Up Survey Assessment: The Department reviewed 71 randomly selected call inquiry files. Of these, 28 files (39%)[27] should have been identified as a grievance.

Case Examples

- **DMHC File 25:** Review of the audio file revealed the enrollee was having problems paying a pharmacy bill. He called the billing department, but the Plan's system did not recognize the medical record number he entered. The enrollee stated, "When I go online…when I go to billing, it says billing is not available." The enrollee tried to access billing at kp.org through several devices, went to the website listed on the bill, and was unable to access the bill. Since the enrollee expressed dissatisfaction with and complained about not being able to access and pay his bill through the Plan's online billing system, this matter should have been handled as a grievance.

- **DMHC File 32:** Review of the audio for this file revealed the enrollee stated she called previously to address the issue of her maiden name appearing on her account. The enrollee indicated she had been married for several years and already submitted the name change forms. Also, her new Kaiser account was connected with an old account she had 10 years ago and she lost all of her previous medical information. She wanted to combine the two accounts and was told the issue would be resolved and it was not, necessitating a second call. Since the enrollee expressed dissatisfaction with and complained about the two previously unresolved issues, this matter should have been handled as a grievance.

[27] DMHC Call Inquiry Files: 4, 7, 9, 11, 18, 22-25, 31-35, 37-39, 47, 54-56, 58, 61-62, 65, 68, 71-72

TABLE 2
Call Inquiry File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiry	71	Expressions of dissatisfaction, complaints, disputes, requests for reconsideration or appeals must be processed as grievances	43 (61%)	28 (39%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds the Plan provided additional training to staff to assist in differentiating between a grievance and an inquiry and conducted internal audits of its customer service calls. However, the Department's review of the Plan's call inquiry files demonstrated the Plan's customer service representatives do not consistently identify grievances.

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

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

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

Plan's Follow-Up Compliance Effort: As required in the Final Report, the Plan submitted a supplemental response outlining a corrective action plan that stated:

- The Plan will update the Resolution Requirements section of the California Non-Medicare Grievance and Appeals Policy to require all medical necessity denial letters state the clinical reasons related to medical necessity for the decisions and cite the applicable criteria, clinical guidelines, or medical policies by May 1, 2021
- The Plan will train Program Representatives on identification of appropriate criteria by May 1, 2021.
- The Plan will issue a communication notifying Permanente Medical Group chiefs of this corrective action plan by May 15, 2021.
- The Plan will deploy use of criteria in connection with the grievance decision-making process related to medical necessity by June 1, 2021.

In its response to the Department's notice to conduct the Follow-Up Survey, the Plan stated it:

- Updated the Resolution Requirements section of the California Non-Medicare Grievance and Appeals Policy to require all medical necessity denial letters state the clinical reasons related to medical necessity for the decisions and cite the applicable criteria, clinical guidelines, or medical policies on April 30, 2021.
- Trained Program Representatives on the identification of appropriate criteria. For example, Program Representatives received Milliman Care Guidelines (MCG) Care Web Training and a reference guide on how to use the MCG Care Resource Document.
- Implemented a new process involving the use of criteria in connection with the grievance decision-making process related to medical necessity, effective June 1, 2021.
- The Plan issued a communication notifying Permanente Medical Group chiefs of the corrective action plan on April 21, 2021. The communication informed the chiefs of the deficiency and how the Plan will introduce the use of third-party guidelines to support clinical decisions regarding member grievances involving medical necessity.

Supporting Documentation:

- DEF4_1 Narrative Description (December 9, 2021)
- DEF4_4 Memo to The Permanente Medical Group chiefs (April 21, 2021)[28]
- 70 Standard Grievance Batch A Files (August 2, 2021 through October 29, 2021)
- 61 Expedited Grievance Files (August 2, 2021 through October 22, 2021)

Follow-Up Survey Assessment: The memo to The Permanente Medical Group (TPMG) department chiefs states:

> DMHC has repeatedly cited the Health Plan for allegedly deficient and inadequate member resolution letters involving medical necessity denials. Under governing law, the Health Plan is required to cite the "criteria, clinical guidelines or medical policies used in reaching the determination" regarding medical necessity. During the 2019 DMHC Routine Medical Survey, DMHC rejected the Health Plan's long-standing defense of citing only the clinical judgment of Plan providers in such resolution letters.
>
> As a result, the Health Plan will introduce the use of third-party guidelines for purposes of supporting clinical decisions regarding member grievances involving medical necessity, effective June 1, 2021. Use of these guidelines is limited to member grievances with a medical necessity component.

[28] The subject of the memo is "Action Required: Member Grievances Involving Medical Necessity." TPMG Associate Executive Directors sent this message to all department Chiefs and Assistant Physicians in Charge (APICs) for Outside Services. The department Chiefs and APICs were instructed to "share the message with physicians in your department who review member grievances."

During interviews, Plan staff confirmed it began using MCG criteria for medical necessity decisions within the grievance process on June 1, 2021 as part of its corrective action plan.

The Department reviewed 70 randomly selected standard grievance files (Batch A). Of these, 18 files involved a delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary.[29] Of these 18 files, eight files (44%)[30] contained written responses from the Plan that failed to include a description of the criteria or clinical reasons for the Plan's decision.

The Department reviewed 61 randomly selected expedited grievance files. Of these, 46 files involved a delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary.[31] Of these 46 files, 11 files (24%)[32] contained written responses from the Plan that failed to include a description of the criteria or clinical reasons for the Plan's decision.

Case Examples

- **DMHC Standard Grievance File #13:** The enrollee requested a repeat breast ultrasound at a different facility because the previous ultrasound technician did not "examine everything I wanted her to examine." The Plan's written response to the enrollee stated:

  > … based on a thorough review of the ultrasound report, the Radiology Technician performed an ultrasound of both breasts. There were no masses or cysts noted in the right breast. However, a mass on the left breast was noted and further investigated as explained in the email sent by your primary care physician Dr. Marja Paulino on September 17, 2021. Therefore, the PIC determined that a repeat breast ultrasound is not medically indicated at this time…
  >
  > As stated in [the "Benefits and Your Cost Share" section of your Evidence of Coverage (EOC)], services are covered if medically necessary and provided, prescribed, authorized, or directed by a Plan Physician…

  While the Plan's response states the clinical reasons for the denial, the letter only referenced the EOC and did not cite the MCG criteria. Therefore, the file is deficient for failing to describe the criteria related to medical necessity used in reaching the determination.

[29] DMHC Standard Grievance Batch A Files: 3, 8, 13-15, 21, 23, 25, 42, 47, 50-52, 59, 64, 69-70, 74
[30] DMHC Standard Grievance Batch A Files: 3, 13, 15, 42, 51, 64, 70, 74
[31] DMHC Expedited Grievance Files: 1-3, 5, 8-11, 13-17, 19-20, 23-28, 30, 32-34, 36-38, 40-42, 44, 46-58, 61
[32] DMHC Expedited Grievance Files: 1, 10, 15, 25, 27, 33-34, 40, 54, 57-58

- **DMHC Expedited Grievance File #27:** The enrollee requested an earlier surgery date. The Plan's written response to the enrollee stated:

  > …we want to let you know we've denied your request…a sooner surgery date is not medically necessary at this time…during your most recent Emergency Department visit…there was no evidence of any acute urgent/emergent abdominal findings…you have had this abdominal pain for over 2 years now and are currently scheduled for an elective, non-cancer surgery for chronic abdominal pain…
  >
  > This denial is based on your agreement with Kaiser Permanente…In your 2021 Evidence of Coverage (EOC), it states that we only cover services that are medically necessary and provided, prescribed, authorized, or directed by a Kaiser Permanente Plan physician.

  While the Plan's response states the clinical reasons for the denial, the letter only referenced the EOC and did not cite the MCG criteria. Therefore, the file is deficient for failing to describe the criteria related to medical necessity used in reaching the determination.

TABLE 3
Standard Grievance and Expedited Grievance File Review

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard grievance involving a delay, denial or modification of health care services	18	Plan's response describes the criteria or guideline used and clinical reasons for its decision	10 (56%)	8 (44%)
Expedited grievance involving a delay, denial or modification of health care services	46	Plan's response describes the criteria or guideline used and clinical reasons for its decision	35 (76%)	11 (24%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds the Plan has taken steps to correct this deficiency by implementing the use of MCG criteria in decisions involving medical necessity in its grievance process. However, the Department's review of standard and expedited grievance files demonstrates the Plan's responses do not consistently reference MCG

or any other clinical criteria related to medical necessity used in reaching the determination.

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

UTILIZATION MANAGEMENT

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

Regulatory References: Rule 1300.70(a)(3), (c).

Plan's Follow-Up Compliance Effort: As required in the Final Report, the Plan submitted a supplemental response stating the Plan committees responsible for creating this CAP agreed on a 2021workplan to concentrate on a subset of measures and activities focusing on under- and over-utilization of services to ensure professionally recognized standards of practice are met. These workplans will be reviewed and updated annually or as often as needed by the appropriate Plan committees.

Additionally, in response to the Department's notice to conduct the Follow-Up Survey, the Plan submitted narrative responses – one for the Northern California region (NCAL) and one for the Southern California region (SCAL) detailing the Plan's continued efforts to correct this deficiency.

The NCAL narrative response indicated the Plan implemented a new initiative in June 2021, whereby action teams are required to routinely present utilization reports to its Resource Management Committee (RMC), which oversees Plan utilization. The RMC will analyze the reports, which will include metric analysis, as well as action items of potential over- and/or under-utilization of services, to ensure professionally recognized standards of practice are maintained.

The SCAL narrative response indicated effective May 2021, the Plan implemented review of overuse and appropriateness measures to identify potential over- and/or under-utilization of services. This will be a standing agenda item for every meeting of the Southern California Strategic Goals Steering Committee (CSGSC), which occurs quarterly. Additionally, effective July 2021, action teams or appropriateness committees have been required to routinely present utilization reports to the Utilization Management Steering Committee (UMSC), and two times annually thereafter. The reports included metric analysis, as well as action items of potential over- and/or under-utilization of services, to ensure professionally recognized standards of practice are maintained.

Supporting Documentation:

- DEF5_1 Narrative Description (December 9, 2021)
- Regional Resource Management Committee 2021 Charter (December 19, 2021)
- Kaiser Foundation Health Plan, Inc., Northern California Region 2020 Utilization Management (UM)/Resource Management Program Description (August 20, 2020)

- DEF5_1 NCAL Over/Under Utilization List of Key Metrics (December 19, 2021)
- Quality Oversight Committee Meeting Minutes (April 14, 2021, July 14, 2021, October 31, 2021)
- Resource Management Committee Meeting Minutes (May 25, 2021, June 22, 2021, July 14, 2021, September 28, 2021, October 13, 2021)
- DRUG Report Key Points (June 2021, July 2021, August 2021, September 2021, October 2021)
- DEF5_1 SCAL Addendum 1 – UMSC 2021 Charter FINAL (December 19, 2021)
- Utilization Management Program Description 2021, Kaiser Foundation Health Plan, Southern Region (December 19, 2021)
- Utilization Management Steering Committee Meeting Minutes (July 19, 2021, August 16, 2021, September 20, 2021)
- Utilization Management Steering Committee Executive Summaries (July 19, 2021, August 16, 2021, September 20, 2021)
- Southern California Clinical Strategic Goals (CSG) Steering Committee Meeting Minutes (May 5, 2021)
- Clinical Strategic Goals HEDIS APM and AAB Measures for Utilization Management Steering Committee (September 20, 2021)
- Imaging Appropriateness Committee Utilization Management Steering Committee Report Out HEDIS Low Back Pain (July 19, 2021)

Follow-Up Survey Assessment:

a. Northern California Region

The Regional Resource Management Committee 2021 Charter describes the activities of the RMC and identifies the RMC as a subcommittee of the Quality Oversight Committee (QOC).[33] The Charter defines over-utilization as "providing clinical services that are not clearly indicated, or providing services in excessive amounts, or in a higher level of setting that is required."[34] Under-utilization is defined as "failure to provide appropriate or indicated services, or provisions of an inadequate quantity or lower level of services than required."[35]

One of the RMC's listed functions is "Regular review of Over/Under Utilization in select clinical arenas."[36] However, the "select clinical arenas" are not identified. It is also unknown how these select clinical arenas were chosen. The RMC meets "no less than monthly for a minimum of eight meetings per year."[37]

The Plan's UM program describes "the program's structure, scope, processes and information sources used in UM and [Resource Management (RM)]."[38] The UM program

[33] Regional Resource Management Committee 2021 Charter, page 1.
[34] *Id*.
[35] *Id*.
[36] *Id*., page 2.
[37] *Id*., page 3.
[38] 2020 Utilization Management (UM)/Resource Management Program Description, page 4.

includes a section titled "Monitoring Under and Over-Utilization and Appropriate Utilization," which states:

> KFHP monitors the over and under-utilization of services through a variety of activities and through numerous health plan venues across the continuum. The lens through which we evaluate utilization is via appropriate utilization to achieve Quality Outcomes. KFHP measures utilization using metrics and activities which may not traditionally be viewed as over and under-utilization measures…
>
> …under/over utilization is reviewed at the medical center level thru analysis of (but not limited to):
>
> - Outpatient Medical Center Quality Reports measuring appropriate utilization
> - Vaccination rates to identify possible underutilization
> - Hospital readmissions which can suggest overutilization and inform admission prevention strategies such as enrollment in a chronic condition case management program[39]
> - Pharmacy utilization activities such as antibiotic stewardship and de-prescribing strategies for senior adults to reduce overutilization.[40]

The Plan provided a list of NCAL key metrics for over- and under-utilization that includes:

> Overuse/Over-utilization Measures:
> - Non-Recommended Cervical CA Screening in Adolescent Females
> - Use of Imaging Studies for Low Back Pain
> - Pharmacy Utilization report
> - Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
> - IMAGAC Radiology Report for other imaging modalities
> - Appropriate use of Antibiotics for Children with Upper Respiratory Infection
>
> Underuse/Under-utilization Measures:
> - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
> - Alcohol and Drug Treatment (Initiation and Engagement)
> - Follow-up care after Psychiatric Hospitalization (7 and 30 days)
> - Metabolic Monitoring on [sic] Children on Antipsychotics

Although the Plan added measures to the list in the 2020 UM/RM Program Description, there was no indication how the Plan chose these measures, these measures are still a subset of all HEDIS measures, and the list of underuse/under-utilization measures is

[39] Of note, hospital readmissions are typically an indication of under-utilization, as high hospital readmission rates usually represent facility under-utilization associated with aggressive discharge policies in the system, resulting in an enrollee being discharged too soon and needing to be readmitted.
[40] 2020 Utilization Management (UM)/Resource Management Program Description, pages 12-13.

only for behavioral health-related services. Moreover, some of these "key metrics" are outcome-driven initiatives (e.g., appropriate antibiotic use or first-line psychosocial care), rather than identification of data to demonstrate over- and under-utilization of resources. Finally, this list is an undated Word document with no reference to the Plan (e.g., not on Plan letterhead). It is unknown who created this document and whether this document is connected to the Plan's documented UM program.

The Department reviewed the Plan's Quality Oversight Committee (QOC) meeting minutes dated April 14, 2021, July 14, 2021, and October 13, 2021.

- The April meeting minutes included discussions about the routine survey findings regarding this deficiency, indicating the Plan would look at different metrics for monitoring for over- and under-utilization, and that new over- and under-utilization reports would be coming to the RMC starting in the summer.[41]

- The July meeting minutes included discussions about adding over- and under-utilization language to the UM Program Description, RMC charter, and RMC tracker; presenting the National Committee on Quality Assurance's (NCQA) definition of over-/under-utilization to the RMC; and the Plan's comparison of its over- and under-utilization findings with NCQA benchmarks as a means of measuring successes.[42]

- The October meeting minutes included discussions about the role of the Health Plan Physician Advisor (HPPA), who would serve as the Plan's "clinical expert and consultant on a wide variety of clinical practice and benefits issues and oversee compliance with relevant California statutes."[43] Using the NCQA definition of over- and under-utilization, the HPPA will collaborates with SCAL to monitor and evaluate "utilization from a quality lens." [44]

  In addition, "the first report went to RMC in June 2021, with utilization reports included in the RMC quarterly reports to QOC."[45] The minutes documented review of the annual Imaging Appropriateness Committee (IMAGAC) Radiology Overutilization Analysis report,[46] listed four focus areas,[47] and merely stated, "The report included information on appropriate imaging studies and included strategies where needed."[48] However, this was a brief report summary. No additional information or evidence of the data upon which the report was based was provided.

[41] Quality Oversight Committee Minutes, April 14, 2021, page 2.
[42] Quality Oversight Committee Minutes, July 14, 2021, page 1.
[43] Quality Oversight Committee Minutes, October 13, 2021, page 1.
[44] *Id*.
[45] *Id*.
[46] The IMAGAC is a regional committee with the goal of "reduc[ing] wasteful spending of needless imaging."
[47] The four focus areas are: (1) impact access to truly needful, (2) radiation overexposure in select cases, (3), financial toxicity: direct & indirect, and (4) incidentaloma: costing & anxiety.
[48] Quality Oversight Committee Minutes, October 13, 2021, page 3.

Notably, these three sets of QOC meeting minutes were heavily redacted. The limited portions of the minutes provided did not demonstrate monitoring, data gathering or analysis of utilization of services beyond vague outcome targets and strategies.

The Department also reviewed the Plan's RMC meeting minutes dated May 25, 2021, June 22, 2021, July 14, 2021, September 28, 2021, and October 13, 2021.

- The May meeting minutes is a one-page document with no documented substantive discussion. There is a reference to this deficiency, an indication that staff "presented changes and updates made to the UM Program Description, RMC Charter and RMC tracker to include Over/Under Utilization language," and a "semiannual analysis scheduled to be presented to the RMC committee staring [sic] with June 22nd meeting."[49] There was no other discussion of over- and under-utilization monitoring.

- The June meeting minutes referenced the topic of "Bi-Annual Report of Over/Under Utilization Measurement Performance," which is "an overview of KP NCAL's Over/Under Utilization performance to the RMC."[50] However, the details of this report are unknown. There was also a discussion of appropriate antibiotic use for children with upper respiratory infections, and the provision of secure messaging for follow-up after an ER visit for mental illness. A list of key metrics was included in the minutes, along with performance percentages against HEDIS benchmarks.[51] Twelve out of 15 pages of meeting minutes were redacted.

- The July meeting minutes were labeled RMC meeting minutes, but were actually QOC meeting minutes containing a report from the RMC,[52] and the minutes documented the same information and benchmarks as the June meeting minutes. Seven out of nine pages of the report were redacted.

- The September meeting minutes documented an annual review of over-utilization for IMAGAC Radiology, including brain magnetic resonance for atraumatic headache and dementia, compression venous sonogram for deep vein thrombosis, and CT after cancelled stroke alert. Although there were charts and graphs to illustrate findings, it is unknown whether there was any discussion of findings, as approximately five out of nine pages of meeting minutes were redacted.

  There was an HPPA report included in the minutes, indicating "the [RMC] revised its charter and reporting calendar to examine select areas of Over/Under Utilization" and "the guiding foundation for this review was the NCQA definition of Over/Under Utilization."[53] In addition, "The first report of Over/Under utilization

[49] Resource Management Committee Meeting Minutes, May 24, 2021, page 1.
[50] Resource Management Committee Meeting Minutes, June 22, 2021, page 1.
[51] *Id*., pages 1-2.
[52] Title of Report: QOC Subcommittee, Resource Management Committee, Second Quarterly Report 2021.
[53] Resource Management Committee Meeting Minutes, September 28, 2021, pages 5-6.

was presented to the [RMC] in June 2021."[54] Again, it unknown whether any discussion took place, as more than half of the meeting minutes were redacted.

- The October meeting minutes were labeled RMC meeting minutes, but were actually QOC meeting minutes containing a report from the RMC.[55] The report contains the Annual HPPA Report, again indicating the RMC revised its charter and reporting calendar to "examine select areas of Over/Under Utilization" and that the "guiding foundation for this review was the NCQA definition of Over/Under Utilization."[56] The report also includes the "Annual IMAGAC Radiology Over Utilization Analysis," but it is unknown whether any discussion took place, as approximately five out of eight pages of the report were redacted.

These heavily redacted RMC meeting minutes and reports neither document meaningful data gathering for assessing over- and under-utilization of services, nor do they demonstrate any analysis of the utilization of services beyond outcome targets and strategies. Furthermore, instead of monitoring the over- and under-utilization of all health care services, the Plan's RMC meeting minutes and reports indicate the Plan's intent to merely examine "select areas" of over- and under-utilization.[57,58]

The Plan's DRUG Report Key Points reviews drug use management for the Plan's medical centers, focusing on 13 initiatives undertaken by the Plan, which include the following:

- Choose Formulary and Generics
- Preferred ADHD Medications in Adults and Pediatrics
- Reduction of Non-Formulary Dipeptidyl Peptidase-4 Inhibitors (DPP-4) in Adults with Type 2 Diabetes
- Appropriate Use of Direct Oral Anticoagulants (DOACs) for Treatment of VTE
- Preferred HIV Pre-Exposure Prophylaxis (PrEP) Therapy
- Polypharmacy: Avoid the Use of Multiple CNS-Active Medications in Older Adults
- Polypharmacy: Avoid the Use of Multiple Anticholinergic Medications in Older Adults
- Avoidance of Antibiotics- Acute Bronchitis
- Avoidance of Antibiotics- Upper Respiratory Infections
- Avoidance of Antibiotics- Acute Rhinosinusitis
- Avoid Benzodiazepines New Starts in Generalized Anxiety Disorder
- Avoid Concurrent Use of Opioids, and Benzodiazepines or Sedative Hypnotics New Starts
- Opioid Reduction: At the Crossroads of Quality, Safety, Affordability

[54] *Id*., page 6.
[55] Title of Report: QOC Subcommittee, Resource Management Committee, Second Quarterly Report 2021.
[56] Quality Oversight Committee Meeting (October 13, 2021): QOC Subcommittee, Resource Management Committee, Second Quarterly Report 2021, page 2.
[57] Resource Management Committee Meeting Minutes, September 28, 2021, page 6.
[58] Quality Oversight Committee Meeting (October 13, 2021): QOC Subcommittee, Resource Management Committee, Second Quarterly Report 2021, page 2.

The reports also show goals for future initiatives, including the following:

- Appropriate Treatment for Dry Eye Disease (DED)
- Initial Opioid Prescribing – Long Duration
- Initial Opioid Prescribing – Opioid High Dose
- Avoid Concurrent Use of Opioids, and Benzodiazepines/Z Drugs New Starts (RETOOL)

The reports show measures for each initiative and a comparison of how 21 medical centers performed compared to the goals set forth by the Plan. However, all the measures relate to overuse. Moreover, these are outcome-driven initiatives, such as appropriate antibiotic use or appropriate prescribing, rather than identification of data and how it would be collected to demonstrate both over- and under-utilization of pharmacy resources.

b. Southern California Region

The Utilization Management Steering Committee (UMSC) is a subcommittee of the Southern California Quality Committee.[59] The UMSC monitors UM practices and oversees the structure of the UM program to identify potential quality issues, including, "review and analyses of over and underutilization measures and any actions planned or implemented to improve performance."[60] In addition, "Over-Under Utilization is Primarily a Quality function."[61]

The USMC oversees the Plan's Southern California UM Program, including implementation, monitoring and evaluation, and continuous quality improvement.[62] Included in the UMSC's responsibilities is the continuous monitoring of, "utilization of services to ensure they meet professionally recognized standards of practice, which include review and analyses of over and underutilization measures and any actions planned or implemented to improve performance."[63] The USMC meets "as often as necessary but at least six times per year," and provides "periodic reports on its activities to the Southern California Quality Committee."[64]

The Department reviewed the Plan's UMSC meeting minutes dated February 15, 2021, March 15, 2021, July 19, 2021, August 16, 2021, and September 20, 2021.

- The February meeting minutes referenced "DMHC Finding" and documented changes were made to the CSG (Clinical Strategic Goals) charter regarding over- and under-utilization.[65] The CSG charter would show "how the hospital will

[59] Utilization Management Steering Committee 2021 Charter, page 1.
[60] Utilization Management Steering Committee 2021 Charter, page 2.
[61] *Id*.
[62] Utilization Management Program Description 2021, page 22.
[63] *Id*., page 23.
[64] *Id*., page 24.
[65] Utilization Management Steering Committee Meeting Minutes, February 15, 2021, page 2.

monitor the over/under utilization."[66] The meeting minutes did not demonstrate monitoring, data gathering or analysis of utilization of services.

- The March meeting minutes documented over- and under-utilization was added to the standing agenda item and work plan.[67] Additionally, there was a proposal to expand the statement on over- and under-utilization in the UMSC 2021 Charter.[68] The meeting minutes did not demonstrate monitoring, data gathering or analysis of utilization of services. In addition, the March meeting minutes were heavily redacted.

- The July meeting minutes referenced an "Over/Under Utilization" update/discussion on "the Imaging Appropriateness Committee HEDIS Report on Low Back Pain" and an executive summary.[69] All other substantive portions of the meeting minutes were redacted.

  The report uses NCQA's HEDIS Low Back Pain measure to assess "adults with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis."[70] The report identifies an appropriate total volume for the use of these imaging studies for the year 2020, and documents measurements of regional performance standard against HEDIS benchmarks.

  The data and information in the report assess how imaging prescribers, specifically for low back pain, are performing as compared to their peers on a national level. As outliers are identified based on prescribing patterns instead of whether imaging is appropriately prescribed, the Plan is not assessing whether the use of imaging studies for low back pain is overutilized (i.e., prescribed when not clearly indicated) or underutilized (i.e., not prescribed when medically indicated).

- The August meeting minutes referenced an "Over/Under Utilization" update/discussion on "Regional Medication Treatment Appropriateness Committee (MedTAC)" and an executive summary.[71] All other substantive portions of the meeting minutes were redacted.

  The executive summary addresses MedTAC's findings for Opioid High Utilizers and Concurrent Use of Opioids and Benzodiazepines/Non-Benzodiazepine Sedative Hypnotics. With respect to whether any system controls in place that would prevent over- or under-prescribing of medications, the summary states, "there is prescription decision support and EPIC provides the milligram equivalents. There are also alerts and pop-up windows that asks for accuracy confirmation from the ordering physician. However, it is important to note that

[66] *Id*.
[67] Utilization Management Steering Committee Meeting Minutes, March 15, 2021, page 2.
[68] *Id*.
[69] Utilization Management Steering Committee Meeting Minutes, July 19, 2021, page 3.
[70] Utilization Management Steering Committee, Imaging Appropriateness Committee – USMC Report Out HEDIS Low Back Pain, July 19, 2021, page 1.
[71] Utilization Management Steering Committee Meeting Minutes, August 16, 2021, page 4.

these are in place to support the clinical decision, more educational and not a prior authorization requirement."[72]

Specifically regarding over- and under-utilization, the executive summary states, "our group is about optimizing treatment appropriateness to best practice, with a focus on safety and quality of care to our members."[73] Although MedTAC's goal is to optimize treatment and focus on decreasing opioid and benzodiazepine usage, documentation of a decrease in usage is not an assessment of over- and under-utilization. An overall decrease in use does not demonstrate the Plan has identified an issue related to the prescribing of opioids and benzodiazepines when they should not be prescribed, or incidents of not prescribing these drugs when they should be.

- The September meeting minutes referenced an "Over/Under Utilization" metric report on "Metabolic Monitoring measure and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis" and an executive summary.[74] Other than a duplicate reference to the metric report,[75] all other substantive portions of the meeting minutes were redacted.

  The executive summary discusses Metabolic monitoring for Children and Adolescents on Antipsychotics (AMP) and Avoidance of Antibiotic Treatment with Acute Bronchitis (AAB). There is also a Clinical Strategic Goals HEDIS APM and AAB Measures for Utilization Management Steering Committee report on the same topic. The report coincides with and supports the findings in the executive summary. However, again, these are HEDIS measures, and are outcome-driven measures. As noted in the summary, the purpose of metabolic monitoring is for pediatric enrollees routinely using antipsychotic medications and need to be monitored for the onset of side effects that can occur in this population.[76] Although the summary notes this is an example of under-utilization, it is really an assessment of appropriate monitoring, not an assessment of appropriate prescribing (i.e., prescribing such medications when not medically indicated, or not prescribing these medications when they are medically indicated).

Finally, the Department reviewed the Plan's Southern California CSG Steering Committee Meeting minutes dated May 5, 2021. The minutes documented an "Over/Under Utilization" discussion of findings for breast cancer screening with mammography, colorectal cancer screenings, follow-up after Emergency Department Mental Illness for both seven- and 30-day measures, non-recommended cervical cancer screening in adolescent females, appropriate treatment with upper respiratory infection, pediatric well-baby visits, alcohol and drug treatment, use of first-line psychosocial care

[72] Utilization Management Steering Committee Meeting Minutes Executive Summary, August 16, 2021, page 4.
[73] *Id*., page 3.
[74] Utilization Management Steering Committee Meeting Minutes, September 20, 2021, page 4.
[75] *Id*., page 2.
[76] Utilization Management Steering Committee Meeting Minutes Executive Summary, September 20, 2021, Page 3.

for children and adolescents on antipsychotics, and depression screenings.[77] Although some monitored areas listed target percentages for usage of the services, there were no documented findings of actual over- and under-utilization of these services. Moreover, this is a limited subset of services being assessed for utilization.

During interviews, Plan staff indicated the Plan looked at measures that could be benchmarked against other organizations, as well as actionable measures. Plan staff stated the Plan reviews over- and under-utilization through a "quality lens" and although the Plan uses HEDIS benchmarks, which are performed annually, the Plan was performing continuous monitoring of the measures. The Department questioned the Plan regarding monitoring of the referral process for over- and under-utilization. Plan staff indicated the Plan did not follow referrals for services, and instead focuses more on access and capacity rather than over- and under-utilization.

Follow-Up Report Deficiency Status: Not Corrected

Although the Plan has taken steps to correct this deficiency, it failed to provide evidence it is monitoring over-and under-utilization for the full range of health care services offered. Instead, the Plan's submitted reports, metrics, and meeting minutes document the implementation of strategies for assessing how the Plan's providers compare to national benchmarks for a chosen set of designated clinical services and whether the Plan has implemented certain goal-based initiatives to support effective resource use.

The Plan's goal-based monitoring continues to focus on outcome-driven initiatives and HEDIS-based measures to meet HEDIS requirements for NCQA certification rather than monitor over- and under-utilization by its prescribers, assessing whether clinical services are received when indicated in accordance with professionally recognized standards of practice, and taking action to effectively address identified issues.

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

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

Statutory/Regulatory References: Section 1262.8(f)(1); Section 1371.4(b), (d), (j)(1), (j)(2)(B)-(C), (j)(3); Section 1386(b)(1); Rule 1300.71.4(a), (b)(1)-(3), (d).

Plan's Follow-Up Compliance Effort: As required in the Final Report, the Plan submitted a supplemental response describing its proposed post-stabilization process changes. The corrective actions include staff training for its Emergency Prospective Review Program (EPRP) and Outside Utilization Resource Services (OURS) departments regarding receipt and workflow of requests for authorization of post-stabilization care, and revisions to its process for written communications regarding requests for authorization for post-stabilization care.

[77] Southern California Clinical Strategic Goals Steering Committee Meeting Minutes, May 5, 2021, pages 2-6.

In response to the Department's notice to conduct the Follow-Up Survey, the Plan submitted a narrative description of its efforts since implementing its corrective action plan, including:

- Assessing the impact of deficiency findings on existing processes and mapping a comprehensive workflow to capture ideal state of operation to ensure the deficiency is addressed and corrected;
- Collaborating with Plan Claims and Clinical Review departments to finalize new workflows/processes and ensure alignment across the enterprise;
- Partnering with Plan legal counsel to prepare a comprehensive, combined updated policy governing outside medical care coordination, notification, and Post-Stabilization Authorization processes;
- Reviewing, revising and finalizing multiple template letters in connection with outside medical care coordination, notification, and Post-Stabilization Authorization processes;
- Engaging Plan IT functions to create deployment timeline and ensure technical integrity of implementation; and
- Developing comprehensive training materials to prepare for and ensure successful implementation of supplemental corrective action plan.

However, the response further indicated:

> In late **July 2021** California experienced a fourth COVID pandemic surge. Hospitals statewide experienced surge census challenges, and as a result, Kaiser Permanente paused its member repatriation processes. In addition, the Plan took steps to ensure no denials for unauthorized post-stabilization care were issued…due to the surge, Delta variant, and associated uncertainty, the Plan would be unable to commence its planned August 2021 implementation and training of staff on new processes, and would therefore need to pause implementation efforts for an undetermined amount of time.
>
> Given continued uncertainty around COVID-19 variants and upcoming flu season…the Plan has determined it is prudent to continue to pause implementation until Kaiser Permanente personnel have appropriate bandwidth to focus on training efforts, internalize the new processes, and practice putting them into action. The Plan is currently targeting commencing training and implementation efforts in March 2022, assuming both COVID and flu are well controlled by then. In the interim, the Plan has continued to ensure that it does not issue any post-stabilization request denials.

Supporting Documentation:

- DEF6_1 Narrative Description (December 9, 2021)

Follow-Up Survey Assessment: As noted above, the Plan paused its trainings and CAP implementation process in July 2021. In addition, the Plan stated it would not deny any post-stabilization requests. During interviews, the Plan confirmed it was not issuing

denials. The Plan also represented it had not issued any denials during the modified review period of November 1, 2021 through January 31, 2022.

Accordingly, the Department will defer its determination as to whether the Plan has corrected this deficiency until the Plan's next routine survey. This will provide the Plan with sufficient time to implement all proposed corrective actions necessary to remedy this deficiency.

Follow-Up Report Deficiency Status: Not Corrected

To give the Plan adequate time and opportunity to implement these corrective actions, the Department will assess this finding at the Plan's next routine medical survey.

PRESCRIPTION (RX) DRUG COVERAGE

Deficiency #7: The Plan does not update its formulary on a monthly basis. (Statewide)

Statutory References: Section 1367.205(a)(1)-(3).

Plan's Follow-Up Compliance Effort: In response to the Department's notice to conduct the Follow-Up Survey, the Plan stated on June 18, 2020, it implemented an audit and monitoring process by National Pharmacy Benefits (NPB) to ensure accurate monthly web posting. Additionally, in July 2020, the Plan implemented a "new process adopted at both Pharmacy and Therapeutics (P&T) committees (SCPMG and TPMG) to include a dedicated section reflecting monthly formulary updates and updates to KP.org."

Supporting Documentation:

- DEF7_1 Narrative Description (December 9, 2021)
- TPMG Regional P&T Committee Policy and California Pharmacy Operations Pharmacy Policy (March 15, 2021)
- SCPMG Regional Pharmacy & Therapeutics (P&T) Committee Policy and Southern California Pharmacy Operations Pharmacy Policy (March 15, 2021)
- DEF7_4 TPMG Regional Pharmacy & Therapeutics Committee Meeting Minutes (March 2021 through September 2021)
- DEF7_4 SCPMG Regional Pharmacy & Therapeutics Committee Meeting Minutes (February 2021 through September 2021)
- DEF7_5 Formulary Submission and Posting Audit Log (January 2021 through October 2021)
- Plan Website (Last visited February 22, 2024)[78]

Follow-Up Survey Assessment: The Plan's Northern California and Southern California pharmacy operations policies describe the P&T committee's responsibilities and processes for formulary development, revision, and utilization management activities. The policies state:

[78] Link to the Plan's website

> A list of all Commercial Formulary products (The Consumer Formulary) are maintained and made available to all Members, non-participating practitioners, and the public, via [Plan Website] and are updated on a monthly basis. Upon request, a hard copy of The Consumer Formulary may be obtained through the Member Services Departments as required by California law.[79,80]

The Department reviewed the Plan's P&T Committee meeting minutes for both the Northern and Southern California regions. The meeting minutes reflect discussion of monthly formulary updates and updates to the Plan's website.

The Plan's 2021 Formulary Submission and Posting Audit Log documents the dates of P&T Committee decisions, effective dates of the decisions, and the dates Plan staff conducted quality assurance activities to ensure the Plan's website and printable formularies were updated with any changes. Although the log reflects the P&T Committee itself meets every other month, the log demonstrates monthly review of the Plan's formulary website postings.

During Plan interviews, the Plan's Senior Manager of Drug Intelligence and Strategy (Statewide) and the Manager of Pharmacy Formulary and Benefits Monitoring (Statewide) explained how the updates were made throughout the review period, noting that an update was confirmed each month even if there were no changes to the formulary being made. The Plan's Formulary Submission and Posting Audit Log confirmed this as well.

The Department evaluated the Plan's website and found the formularies posted to the Plan's website display the month and year the formulary was updated. The Northern and Southern California formularies both state, "Last Update: February, 2024."[81,82]

Follow-Up Report Deficiency Status: Corrected

The Department finds the Plan has implemented corrective actions to ensure its prescription drug formulary is updated monthly. The Plan's policies are consistent with this requirement, and although the Plan's P&T Committee meets every other month, the Plan's formulary audit log demonstrated documentation of monthly formulary updates. Additionally, Plan interviews clarified the information on the audit log and confirmed the updates were taking place monthly. Finally, the Plan's website demonstrates compliance with the requirement.

Based upon the corrective actions undertaken, the Department has determined this deficiency has been corrected.

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[79] TPMG Regional P&T Committee Policy and California Pharmacy Operations Pharmacy Policy, page 21.
[80] SCPMG Regional Pharmacy & Therapeutics (P&T) Committee Policy and Southern California Pharmacy Operations Pharmacy Policy, page 21.
[81] Link to Plan's Northern California Formulary
[82] Link to Plan's Southern California Formulary

SECTION II: SURVEY CONCLUSION

Issuance of this Follow-Up Report concludes the Routine Survey of the Plan. The Department finds the Plan has corrected two of the seven deficiencies that remained uncorrected upon issuance of the Final Report on February 11, 2021.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), please submit the response via the Department's Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

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

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2019 Routine Full Service Survey - Document Request**.
- Submit the response to the Follow-Up Report via the Department Communication tab.

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

Any uncorrected deficiencies identified in this Report will be referred to the Department's Office of Enforcement for potential further action.

Plan Response to the Follow Up Report