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DEPARTMENT OF MANAGED HEALTH CARE
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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	Enforcement Matter No.: 11-543
KAISER FOUNDATION HEALTH PLAN INC.,	**ACCUSATION**
Respondent.	

I.

INTRODUCTION

The California Department of Managed Health Care ("DMHC" or "the Department") brings the present action to assess administrative penalties against Kaiser Foundation Health Plan Inc., ("Respondent" or "the Plan") for violations of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act" or "the Act") (Health & Saf. Code, § 1340, et seq.), and California Code of Regulations, title 28, promulgated pursuant to the Knox-Keene Act. Respondent is a health care service plan licensed under and regulated by the Knox-Keene Act.

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II.

PARTIES

1. Carol L. Ventura is the Acting Deputy Director | Chief Counsel of the Office of Enforcement for the Department of Managed Health Care (the Petitioner). Petitioner brings this Accusation solely in her official capacity as Acting Deputy Director | Chief Counsel of the Office of Enforcement for the Department of Managed Health Care.

2. Respondent is now, and has been since November 4, 1977, a full service plan (File No. 933 0055) as defined by Health and Safety Code section 1345, subdivision (f), licensed pursuant to Health and Safety Code, section 1353. Its principal place of business is located at 2101 Webster Street, Oakland, CA 94612. Kaiser is subject to the Knox-Keene Act and California Code of Regulations, title 28, promulgated pursuant to the Knox-Keene Act.

III.

STATUTORY AUTHORITY

3. This Accusation is brought before the Director of the Department ("Director") under the authority conferred in the Act and title 28 of the California Code of Regulations, as specified below.

4. The Department is charged with the task of regulating managed health care in the State of California and ensuring that the entities which sell managed health care products in California, known as health care service plans ("health plans"), are in compliance with their obligations under the Act. (Health & Saf. Code, §§ 1341(a), 1345(f).)

5. The Director is responsible for the performance of all duties and responsibilities vested by law in the Department, including the administration and enforcement of the Act and the rules and regulations adopted thereunder. (Health & Saf. Code, §§ 1341(c), 1346(a)(5).)

6. Health and Safety Code section 1386(a) authorizes the Director to take disciplinary action against a health care service plan under appropriate circumstances. The Director is authorized to assess administrative penalties against a health plan if the Director determines, after appropriate notice and opportunity for a hearing, that the health plan has committed any of the acts or omissions enumerated in section 1386(b), which constitute grounds for disciplinary action.

7. Health and Safety Code section 1386(b)(6) provides that a health plan may be subject to disciplinary action if it violates any provision or rule of the Act or any order issued by the Director.

8. California Code of Regulations, title 28, section 1300.67.2.2(c)(1) states that plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice and that plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

9. California Code of Regulations, title 28, section 1300.67.2.2(c)(5) requires each plan to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

- Urgent care appointments for services by a Physician or non-physician provider that do not require prior authorization: within 48 hours of the request for appointment,
- Non-urgent appointments with specialist Physicians, such as psychiatrists: within fifteen business days of the request for appointment,
- Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment.

10. California Code of Regulations, title 28, section 1300.67.2.2(d) requires each plan to have written quality assurance systems, policies, and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Knox-Keene Act. Compliance monitoring policies and procedures, designed to accurately measure the accessibility and availability of contracted providers, must include tracking and documenting network capacity and availability.

11. California Code of Regulations, title 28, section 1300.70(a)(1) requires the plan's Quality Assurance Program to document that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

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12. California Code of Regulations, title 28, section 1300.70(a)(3) requires a plan's Quality Assurance Program to address service elements, including accessibility, availability, and continuity of care.

13. California Code of Regulations, title 28, section 1300.70(b)(1)(D) requires each plan's Quality Assurance Program be designed to ensure that appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason.

14. California Code of Regulations, title 28, section 1300.70(b)(2)(G)(3) permits plans to utilize medical groups or other provider entities' quality assurance ("QA") programs. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider, the plan is required to have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

15. California Code of Regulations, title 28, section 1300.67(f)(8) provides that the basic health care services required to be covered by the plan include effective health education services, including information regarding the optimal use of health care services provided by the Plan or health care organization affiliated with the Plan.

16. California Code of Regulations, title 28, section 1300.80(b)(6)(B) provides that the Department's medical surveys shall include a review of the availability of health education to enrollees.

17. Health and Safety Code section 1374.72 requires plans to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions.

18. All hearings before the Director are to be held in accordance with the Administrative Procedure Act, and the Director has all of the powers granted under that Act. (Health & Saf. Code, § 1397(a).) The factors for determining an appropriate penalty for violations of the Act are set forth in California Code of Regulations, title 28, section 1300.86.

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IV.

FACTUAL ALLEGATIONS

19. On January 6, 2012, pursuant to Health and Safety Code section 1380, the Department commenced a routine medical survey of the Plan which was completed and closed on July 25, 2012.

20. On March 6, 2013, the Department issued a report to the Plan entitled Final Report Routine Medical Survey of Kaiser Foundation Health Plan, Inc. Behavioral Health Services ("the Final Report") detailing the results of the survey.

21. This Accusation pertains to the subject matter of the Final Report.

22. This Accusation is not intended to nor does it limit the Department's authority to take any and all additional appropriate action as provided under the authority of the Knox-Keene Act and title 28 of the California Code of Regulations to resolve the matters described in the Final Report.

23. With respect to deficiency numbers 1 through 4, the Department will be conducting a follow-up survey in the Fall of 2013 to assess whether the Plan has taken adequate action to correct the deficiencies discussed in the Final Report.

24. The findings in the Final Report, deficiency #1 through #4 state:

> **ACCESS AND AVAILABILITY OF SERVICES**
> #1 The Plan does not ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards. (Cal. Code Regs., tit., 28 § 1300.67.2.2, subds. (c)(1), (5); § 1300.67.2.2(d).)
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> #2 The Plan does not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes. (Cal. Code Regs., tit., 28 § 1300.67.2.2, subds. (c)(1), (5); § 1300.67.2.2(d).)
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> **QUALITY MANAGEMENT/ ACCESS AND AVAILABILITY OF SERVICES**
> #3 The Plan's Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care. (Cal. Code Regs., tit., 28 § 1300.70, subds. (a)(1), (3); § 1300.70(b)(1)(D); § 1300.70(b)(2)(G)(3); § 1300.67.2.2, subds. (c)(1), (5); § 1300.67.2.2(d)(3).)
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> **HEALTH EDUCATION SERVICES: MENTAL HEALTH PARITY**
> #4 The Plan does not provide accurate and understandable effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated

with the Plan. (Health & Saf. Code, § 1374.72; Cal. Code Regs., tit., 28 § 1300.67(f)(8); § 1300.80(b)(6)(B).)

25. Deficiency #1, as identified in the Final Report, is the Plan's failure to ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards.

26. The Plan relies upon inaccurate data, effectively preventing the Plan from identifying access problems, and taking action to resolve such problems related to access.

27. Deficiency #2, as identified in the Final Report, is the Plan's failure to sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes.

28. The Plan's methodology for monitoring appointment wait times relies on averaging all reported wait times for a given month.

29. Deficiency #3, as identified in the Final Report, is the failure by the Plan's Quality Assurance Program to ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.

30. The Plan is required to retain responsibility for reviewing the overall quality of care delivered to its enrollees, and to have ongoing oversight to ensure that providers are fulfilling all delegated quality assurance responsibilities. While the Plan, its medical groups, and its medical centers have identified access deficiencies regarding non-compliant appointment wait times, the Plan's reports show that these access deficiencies remained unresolved or, if resolved, were resolved several months after the date of the initial identification.

31. Deficiency #4, as identified in the Final Report, is the failure by the Plan to provide accurate and understandable behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated with the Plan.

32. While the Plan has educational materials available at facilities, some of this information inaccurately describes limitations in benefits that are not compliant with the law, contains misleading or

confusing statements, and makes recommendations that would act to minimize the use of certain health care services.

33. With respect to the each of the deficiencies numbered 1 through 4 of the Final Report, the Plan's attempted corrective action for each of the four deficiencies has not been adequate.

V.

FIRST CAUSE FOR DISCIPLINE

(VIOLATION OF CAL. CODE OF REGS., TIT. 28, § 1300.67.2.2(c)(1), (5); § 1300.67.2.2(d) – FAILURE TO ENSURE THAT THE PLAN'S QUALITY ASSURANCE SYSTEMS ACCURATELY TRACK, MEASURE AND MONITOR THE ACCESSIBILITY AND AVAILABILITY OF CONTRACTED PROVIDERS)

34. Complainant hereby incorporates by reference, paragraphs 1 through 33, inclusive.

35. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386(b)(6).)

36. The Plan is required to accurately track, measure, and monitor the accessibility and availability of contracted providers; the Plan is also required to have written quality assurance systems, policies, and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services.

37. The Plan's access system does not accurately calculate, measure, and monitor the wait times of scheduled appointments, and the Plan does not have adequate quality assurance systems, policies, and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services.

38. Respondent's failure to accurately calculate, measure, and monitor the wait times of scheduled appointments is a violation of California Code of Regulations, title 28, sections 1300.67.2.2 (c) and (d).

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VI.

SECOND CAUSE FOR DISCIPLINE

(VIOLATION OF CAL. CODE OF REGS., TIT. 28, § 1300.67.2.2(c)(1), (5); § 1300.67.2.2(d) – FAILURE TO SUFFICIENTLY MONITOR THE CAPACITY AND AVAILABILITY OF ITS PROVIDER NETWORK IN ORDER TO ENSURE THAT ENROLLEE APPOINTMENTS ARE OFFERED WITHIN REGULATORY TIMEFRAMES)

39. Complainant hereby incorporates by reference, paragraphs 1 through 38, inclusive.

40. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386(b)(6).)

41. The Plan is required to monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes. (California Code of Regulations, title 28, section 1300.70(a)(3) and 1300.67.2.2(c)(1).)

42. The Plan, by utilizing a methodology which averages wait times, has failed to appropriately monitor appointment wait times as required under California Code of Regulations, title 28, section 1300.67.2.2(d). This methodology may mitigate or hide excessive wait times by averaging them with shorter wait times.

43. Respondent's monitoring system failed to alert the Plan to serious timely access issues for individual enrollees, and is a violation of California Code of Regulations, title 28, section 1300.67.2.2(c) and (d).

VII.

THIRD CAUSE FOR DISCIPLINE

(VIOLATION OF CAL. CODE OF REGS., TIT. 28, § 1300.70(a)(1) and (3); § 1300.70(b)(1)(D); § 1300.70(b)(2)(G)(3); § 1300.67.2.2(C)(1) AND (5); AND § 1300.67.2.2(D)(3) – FAILURE TO ESTABLISH AND MAINTAIN A QUALITY ASSURANCE PROGRAM)

44. Complainant hereby incorporates by reference, paragraphs 1 through 43, inclusive.

45. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386(b)(6).)

46. The Plan is required to develop a Quality Assurance program that includes monitoring, evaluation, effective corrective action/resolution, and follow-up of identified availability and accessibility issues.

47. As identified in the Final Report, the Plan, its medical groups, and its medical centers have identified access deficiencies regarding non-compliant appointment wait times, but the Plan has failed to appropriately and timely resolve these access to care issues.

48. Respondent's failure to ensure that its Quality Assurance Program, its medical groups, and its medical centers were taking effective action to improve care where deficiencies are identified is a violation of California Code of Regulations, title 28, section 1300.70.

VIII.

FOURTH CAUSE FOR DISCIPLINE

(VIOLATION OF HEALTH & SAF. CODE, § 1374.72 AND CAL. CODE OF REGS., TIT. 28, § 1300.67(f)(8); § 1300.80(b)(6)(B) – FAILURE TO PROVIDE ACCURATE AND UNDERSTANDABLE EFFECTIVE BEHAVIORAL HEALTH EDUCATION SERVICES)

49. Complainant hereby incorporates by reference, paragraphs 1 through 48, inclusive.

50. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386(b)(6).)

51. The Plan is required to provide consistent and effective health education services.

52. The health education materials used by the Plan failed to ensure that all materials were designed to inform members of available mental health services consistent with the benefits and limitations set forth in the Plan's Evidence of Coverage, misled enrollees regarding benefit coverage, and conflict with state or federal law. These health education materials make recommendations that improperly minimize the use of certain health care services required to be covered by the Plan under the Mental Health Parity Act. The Plan's failure to provide consistent and effective health education services may have discouraged some enrollees from seeking and accessing medically necessary health care services.

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53. The acts of Respondent, as set forth above constitute a violation of Health and Safety Code Section 1374.72 and California Code of Regulations, title 28, section 1300.67(f)(8) and 1300.80(b)(6)(B).

PRAYER

WHEREFORE, Complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty against the Respondent in the amount of $4,000,000.

WHEREFORE, Complainant prays that the Director recover costs incurred in this administrative action, according to proof.

WHEREFORE, Complainant also prays for such other and further relief, as the Director deems proper.

Dated: June 24, 2013

DEPARTMENT OF MANAGED HEALTH CARE

By: Carol L. Ventura

CAROL L. VENTURA
Acting Deputy Director | Chief Counsel
Department of Managed Health Care