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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.: 07-202

Kaiser Foundation Health Plan, Inc. [Non-Routine Medical Survey]) **CONSENT AGREEMENT**

Respondent.

This Consent Agreement is made and entered into on the 26th day of July 2007, by and between KAISER FOUNDATION HEALTH PLAN, INC., a California non-profit public benefit corporation (hereafter "Health Plan"), and the DEPARTMENT OF MANAGED HEALTH CARE (hereafter the "Department") with regard to a non-routine medical survey of certain aspects of the quality assurance program maintained by Health Plan as required by California Health and Safety section 1370 and California Code of Regulations Title 28 section 1300.70 and with regard to the Department's investigation of Health Plan's compliance with these provisions.

WHEREAS, Health Plan is a full service health care service plan, license number 933 0055, subject to the regulatory jurisdiction of the Department under the Knox-Keene Health Care Service Plan Act (Health and Safety Code sections 1340 et seq.) (the "Act").

WHEREAS, a prior Consent Agreement between the parties entered into on August 11, 2006 in Enforcement Matter Number 06-162 concerning the renal transplant center at Kaiser

Foundation Hospitals San Francisco specifically noted concerns regarding Health Plan oversight issues that extended beyond the renal transplant program, and excluded those quality oversight issues from resolution by that Agreement. To address these concerns, the Department undertook a non-routine survey of the Health Plan's overall quality management system.

WHEREAS, the renal transplant program issues, coupled with the progeny of complaints reported in close proximity to this incident, formed a basis of good cause justifying a non-routine survey of Kaiser Foundation Health Plan's Quality Assurance Program as mandated by Section 1370 and associated Rules.

WHEREAS, the Director authorized review of peer review proceedings and records conducted and compiled pursuant to Section 1370 of the Act. Where medical review has been authorized, the survey team is required by law to ensure the confidentiality of the records and information reviewed along with the peer review proceedings.

WHEREAS, the survey team consisted of three physicians with extensive clinical, managed care administration and utilization and quality management experience including previous participation in the Department's routine and non-routine medical survey process; two registered nurses with critical care nursing, managed care and regulatory survey experience; one epidemiologist/quality management specialist; and, one research analyst and one health care management professional to provide quality management and analytical expertise.

WHEREAS, the Department evaluated the Health Plan's quality management oversight processes by: (1) performing interviews with Health Plan regional staff in both Northern and Southern California, (2) examining related Health Plan documents, and, (3) reviewing case files broadly selected from the Health Plan's Medical Centers and offices.

WHEREAS, the Department selected nine Medical Centers: four from Kaiser Permanente Southern California (KPSC) and five from Kaiser Permanente Northern California (KPNC), as a representative sample to assess the Health Plan's quality management oversight program for its 29 Medical Centers as well as the quality management programs administered at the Medical Center level.

WHEREAS, the non-routine survey assessed the Health Plan's system of oversight of quality assurance programs designed to monitor and evaluate care provided to members and the effectiveness of the Medical Center quality programs, inclusive of Peer Review.

WHEREAS, on March 13, 2007, the Department issued its Preliminary Report for the Non-Routine Medical Survey of Kaiser Foundation Health Plan, Inc. (the "Non-Routine Medical Survey"), which listed five areas of deficiencies.

WHEREAS, on May 11, 2007, the Health Plan submitted to the Department a plan of correction that addressed each of the five deficiencies. The Department has accepted Health Plan's plan of correction.

WHEREAS, the Final Report issued to the Plan on July 16, 2007 (the "Final Report") set forth a summary of deficiencies and final Department determination as follows:

A. Health Plan Oversight – Governance. The Survey Team concluded the Health Plan lacked an effective Quality Program oversight system, evidenced by:

1. A lack of monitoring and evaluation of the care provided by the system of providers and facilities. [Health & Safety Code section 1370; CCR title 28, section 1300.70(b)(2)(C)]

STATUS: Health Plan has initiated remedial action and is on its way to achieving acceptable levels of compliance.

2. A failure to inform providers and facilities of the scope of the quality management responsibilities or how it will be monitored by the Health Plan. [CCR title 28, section 1300.70(b)(2)(G)(1) and (3)]

STATUS: CORRECTED

3. A lack of sufficiently detailed quality management reports to the Health Plan's governing body and the delegated quality oversight committees to identify those components presenting significant or chronic quality of care issues. [Health & Safety Code section 1370; CCR title 28, section 1300.70(b)(2)(C)]

STATUS: CORRECTED

B. Peer Review and Quality Programs – Operations Systems. The Survey Team concluded that the variation among all of the Medical Center Quality Management programs, extending to and including the system of peer review formed a basis for the following deficiencies:

1. The Medical Center Peer Review processes are not designed to consistently ensure all quality of care problems are identified and corrected for all provider entities. [Health & Safety Code section 1370; CCR title 28, sections 1300.70(a)(4)(D), 1300.70(b)(1)(A,B)]

STATUS: The Health Plan's completed corrective actions and the corrective actions to be summarized and submitted in its Supplemental Report, due October 1, 2007, are sufficient to demonstrate the Health Plan is on the way to achieving acceptable levels of compliance.

2. The Medical Center Quality Management programs are not designed to consistently ensure all quality of care problems are identified and corrected for provider entities. [Health & Safety Code section 1370; CCR title 28, sections 1300.70(a)(4)(D), 1300.70(b)(1)(A,B)]

STATUS: The Health Plan's completed corrective actions and the corrective actions to be summarized and submitted in its Supplemental Report, due October 1, 2007, are sufficient to demonstrate the Health Plan is on the way to achieving acceptable levels of compliance.

WHEREAS, the Final Report stated the Department's finding that Health Plan is in violation of Section 1370 of the Act and implementing Rule 1300.70 and that the Final Report had been referred to the Department's Office of Enforcement.

WHEREAS, the Department acknowledges the following as factors in mitigation: Health Plan's good faith conduct and cooperation with the Department, Health Plan's correction of two of the five deficiencies prior to the issuance of the Final Report, Health Plan's initiation of a comprehensive plan of correction acceptable to the Department, and Health Plan's commitment to make a substantial investment in effective quality management information systems and training for Health Plan and care delivery system personnel. Pursuant to the Department's requests, Health Plan estimated that total expenditures related to this plan of correction would exceed $12 million, though Health Plan will undertake best efforts to make the implementation as cost effective as possible.

FINALLY, WHEREAS, by entering into this Consent Agreement, Health Plan acknowledges the Department's findings and the opportunities to improve its quality management program, but does not admit any liability or violation of the Act and implementing

rule. However, the parties agree that it is in the best interests of Health Plan's enrollees to enter into this Consent Agreement, and thereby settle the above-referenced enforcement matter and all issues, accusations, and claims that the Department has or may have against Health Plan alleging violation of Health and Safety Code section 1370 and/or implementing Rule section 1300.70 related to, or arising from, any act or omission that may have occurred up to and including the date of this Consent Agreement, including but not limited to the deficiencies identified in the Non-Routine Medical Survey, but not thereafter.

NOW, THEREFORE, the Department and Health Plan mutually agree to enter into this Consent Agreement, as follows:

I. Health Plan shall:

A. Implement the corrective actions to address the deficiencies identified in the Final Report as set forth in Appendix A of this Consent Agreement.

B. Submit evidence of corrective actions taken to the Department's Division of Plan Surveys according to the timeline set forth in Appendix B of the Final Report and restated in Appendix B of this Consent Agreement. The purpose of this timeline is to enable the Department's Division of Plan Surveys to monitor Health Plan's progress towards complete and successful implementation of the plan of correction by the fourth quarter of 2008.

II. The Department and Health Plan may mutually agree to reasonable modifications to the plan of correction and implementation plan provided such agreement is in writing. Such mutual written agreement shall not be considered a failure to comply with this Consent Agreement.

III. The Department has determined that an administrative penalty of $3 million is warranted to resolve the issues encompassed in this Agreement. Health Plan has agreed to pay a sum of $2 million to the Department within ten days after the date of execution of this Consent Agreement. The Department will suspend $1 million of this administrative penalty pending a verification survey by the Division of Plan Surveys in or about the fourth quarter of 2008, with waiver of the suspended amount to be considered and not unreasonably withheld if the Department verifies that Health Plan has implemented all elements of the plan of correction.

IV. The Department will institute a "no notice" spot check audit of a sampling of case files from select Medical Center(s), to begin November 1, 2007. The purpose of such audits is to

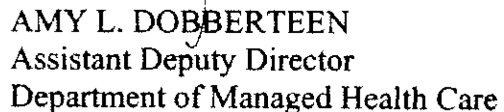
validate early progress in implementation and provide feedback on Health Plan's performance. Health Plan shall continue to make its books and records, including the medical records of its contracted providers, available to the Department in accord with section 1380 of the Health and Safety Code.

V. On or before October 1, 2007, the Health Plan shall submit a Supplemental Report detailing the additional remedial actions and implementation activities undertaken to place into operation the revised standards, policies and procedures and case review addressing the deficiencies described in paragraphs A.1, A.2, A.3, B.1 and B.2 above. The Supplemental Report shall include a final timetable for instituting the Health Plan's revised policies and procedures in all of its 29 Medical Centers.

VI. The Department will monitor the implementation of process changes and review planned audit activities represented in the Plan's corrective action plan; and the Department will verify on an ongoing basis the implementation of the Health Plan's corrective actions through 2008 in addition to the verification survey anticipated to occur in or about the fourth quarter of 2008.

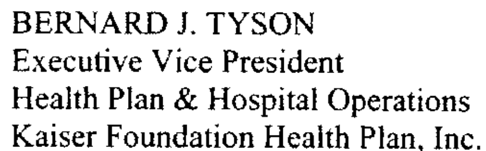
IN WITNESS WHEREOF, the parties hereby execute this Consent Agreement by the signatures of their respective duly authorized officials.

Dated: July 26, 2007



AMY L. DOBBERTEEN
Assistant Deputy Director
Department of Managed Health Care

Dated: July 30, 2007



BERNARD J. TYSON
Executive Vice President
Health Plan & Hospital Operations
Kaiser Foundation Health Plan, Inc.

APPENDIX A

The Department acknowledges the work the Health Plan has begun to address the oversight concerns raised in this survey. The following changes have been initiated and will be implemented over a period of weeks, months and years:

1. Establish a reporting process that will allow the Health Plan to review and monitor, on an ongoing basis, health care delivery system changes instituted on the Medical Center level;
2. Develop a business plan process that provides for the Health Plan's Regional President review and approval of all new or modified clinical services instituted on the Medical Center level;
3. Implement a Peer Review Performance Improvement Project that will establish a uniform set of peer review standards, define and establish a common case severity leveling system and revise case referral and review processes to ensure physicians participating in peer review activities within any clinical department, in either region, conducts a diligent and objective quality review of the appropriateness of physician services and to improve documentation of rationale, conclusions and recommended corrective actions;
4. Implement training at all 29 Medical Centers to educate and orient physicians participating in peer review on new Health Plan standards, criteria and processes in support of changes to the peer review system and to promote consistency throughout Kaiser's clinical departments.
5. Conduct regular ongoing Health Plan audits of its Medical Centers' processes for evaluating and correcting Potential Quality Issues (PQI) to ensure implementation of Program changes and ensure Medical Centers follow new policy;
6. Conduct regular ongoing audits of clinical department-level based peer review programs to confirm changes have been implemented and adhere to both process and content standards, ensuring a standard level of professional practice.

7. Implement new system-wide policies and procedure for the 29 Medical Centers to improve the timely handling and appropriate review and analysis of complaints relating to the quality of care (objective peer review), systems issues or administrative problems.

8. Implement regularly scheduled semi-annual presentations, including standard reporting, by Medical Center leaders to their respective regional Health Plan Quality Committees providing a comprehensive overview, and a mechanism to begin comparisons among Medical Centers; and

9. Establish a Member Concerns Committee (MCC) for its Medical Centers in Southern California which will report on member complaint and grievance processes, and in time, trended information (by region, by facility, and by department) from the Southern Region. This Committee mirrors the activities already underway in Northern California.

10. Revise business requirements, reconfigure computer software, and develop Access database to standardize quality review tracking systems in both Northern and Southern California by the end of the year. The Health Plan has committed to the purchase and installation of a new quality review tracking system in Southern California by 2009.

End Appendix A.

APPENDIX B

TIMELINE FOR SUBMISSION OF EVIDENCE OF IMPLEMENTATION

I. In accordance with the Plan's representations, the Plan will submit to the Division of Plan Surveys evidence of the following by the date indicated:

a. By October 1, 2007:

   i. The Plan will complete the hiring of a triage nurse (RN) for each Member Service Department and the training of all Member Service Department personnel.

b. By November 1, 2007:

   i. Use of revised case screening and referral process for Member Services

   ii. Completion of Northern California system modifications and configuration development.

   iii. Development and implementation of access database for Southern California.

   iv. Complete training related to peer review and department review processes.

c. By December 1, 2007:

   i. Use of revised case screening, referral process for Peer Review

   ii. Use of revised criteria, standards and processes related to quality review in the clinical and administrative departments.

   iii. Use of new criteria, standards and processes for the identification and referral of systems issues.

d. By December 31, 2007:

   i. Availability of modified MIDAS system to all Northern California medical centers, regional offices for purposes of peer review and department review documentation and reporting.

ii. Availability of the access database to all Southern California medical centers and regional offices for purposes of peer review and department review documentation and reporting.

iii. Submit self audit criteria for the medical centers.

e. By February 28, 2008:

i. Sample results of self-audits.

f. After May 2008:

i. Subject to Plan Survey verification: Meeting minutes from regional oversight committees, reflecting documented review and evaluation of new Health Plan required content in medical center reports.

ii. Subject to Plan Survey verification: Evidence of Health Plan validation audit.

iii. Subject to Plan Survey verification: Evidence of Content audit of peer review files performed by PMG physicians outside of California.

g. After October 2008:

i. Subject to Plan Survey verification: Evidence of Continuous Readiness Survey.

II. By October 1, 2007 :

i. Health Plan shall submit a Supplemental Report detailing the additional remedial actions and implementation activities undertaken to place into operation the revised standards, policies and procedures and case review addressing the deficiencies described in paragraphs A.1, A.2, A.3, B.1 and B.2 of the Consent Agreement. The Supplemental Report shall include a final timetable for instituting the Health Plan's revised policies and procedures in all of its 29 Medical Centers and shall clarify, if necessary, the corrective actions agreed upon by the Division of Plan Surveys and Health Plan.

III. In December of 2007:

i. Commencement of submission of applicable quarterly, semi-annual and annual reports by local Medical Center quality committees to regional oversight committees.

End Appendix B.