

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

Contract Number: 07-65849 Sacramento
09-86159 San Diego

Audit Period: September 1, 2018
Through
August 31, 2019

Report Issued: January 17, 2020

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I. INTRODUCTION

Kaiser Foundation Health Plan, Inc. (KFHP) obtained its Knox-Keene license in November 1977 and contracted with the Department of Health Care Services, previously known as Department of Health Services, in 1994 as a Geographic Managed Care (GMC) plan to provide health care services to Medi-Cal beneficiaries in the GMC counties of Sacramento and San Diego.

In 2005, KP Cal, LLC (Plan) was created and licensed as a Knox-Keene plan to hold Kaiser's GMC contracts. The Department of Health Care Services (DHCS) then transferred the GMC contracts to KP Cal, LLC. At that time, KP Cal, LLC and KFHP entered into a management and administrative services agreement to delegate administrative and operational functions such as quality improvement, grievances, and appeals to KFHP. These two entities also entered into a health services agreement to provide health care services to KP Cal, LLC members through KFHP's network of providers and medical centers. KFHP offers a comprehensive health care delivery system including physicians, medical centers, hospitals, laboratories, and pharmacies.

KFHP divides its operations into Northern California (NCAL) and Southern California (SCAL) regions with corresponding responsibilities for the Sacramento and San Diego GMC Contracts. The Sacramento GMC service area includes Sacramento County and members in Amador, El Dorado, and Placer counties who were either previously enrolled or family-linked with KFHP. The San Diego GMC service area includes San Diego County.

As of August 2019, KFHP's total direct GMC contract membership was approximately 147,163. Medi-Cal membership composition was 97,940 for GMC Sacramento and 49,223 for GMC San Diego.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of September 1, 2018 through August 31, 2019. The onsite review was conducted from September 30 through October 11, 2019. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on December 11, 2019. The Plan was allowed to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of September 1, 2017 through August 31, 2018) was issued on May 20, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

This is a combined report for both the Sacramento GMC Contract and San Diego GMC Contracts. Common findings and recommendations are reported under **Sacramento and San Diego GMC**. Unique findings and recommendations are specified as either **Sacramento GMC** or **San Diego GMC**.

The summary of the findings by category follows:

Category 1 – Utilization Management

Sacramento and San Diego GMC

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization (PA) by providing written notification. The Plan did not notify members in writing of decisions to deny or modify PA requests for out-of-plan services.

The Plan is required to refer members identified as potential major organ (except for kidney) transplant candidates to a Medi-Cal approved transplant Center of Excellence (COE) for transplant evaluation. The Plan required extensive medical assessment of members before referring them for transplant evaluation at COE. The Contract did not require establishing transplant suitability, only identification as a potential candidate for transplant, before member referral to a transplant center for evaluation.

The Plan is required to ensure the receipt, review, and resolution of appeals. The Plan did not ensure the receipt, review, and resolution of all member appeals submitted to a delegate to which it did not delegate appeal resolution.

The Plan is required to ensure appeal decision-makers are health care professionals with clinical expertise in treating a beneficiary's condition or disease for appeals involving clinical issues. The Plan did not ensure health care professionals with clinical expertise decided appeals. Non-clinical staff resolved appeals containing clinical issues, and which were for services the Plan had previously denied for not a covered benefit.

Sacramento GMC

The Plan is required to cover outpatient mental health services that are within the scope of practice of primary care physicians. The Plan is required to maintain policies and procedures that define and describe what services are to be provided by primary care providers. The Plan did not maintain policies and procedures that define and describe what services are to be provided by primary care physicians in regards to outpatient mental health services.

The Evidence of Coverage is required to include a description of the full scope of Medi-Cal Managed Care benefits, all available services, and "carve out" services (services available to members that are not covered by the Plan), and an explanation of any service limitations and exclusions from coverage. The Plan did not inform members of all carved out specialty mental health services. The Plan's Evidence of Coverage document did not inform members of the availability of intensive care coordination, intensive home based services, and therapeutic foster care services through the county.

San Diego GMC

The Plan is required to provide or arrange and pay for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for members under the age of 21 years. The Plan did not provide EPSDT services as required. The Plan did not renew requests for speech therapy services as submitted by members' therapists but denied or modified them without applying EPSDT criteria that allowed the services based on medical necessity.

Category 2 – Case Management and Coordination of Care

Sacramento and San Diego GMC

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS. The Plan did not use a DHCS-approved PCS form or have a mechanism to capture and submit data from the PCS form. Transportation records did not contain physical and medical limitations of members, dates of service needed, mode of transportation, or a physician certification statement of medical necessity.

Category 3 – Access and Availability of Care

Sacramento and San Diego GMC

Category three covers appointment procedures and monitoring wait times for routine, urgent, and emergency care appointments, and access to specialists and specialty care.

The Plan is required to provide members a printed Provider Directory upon request. The Plan did not maintain a DHCS approved printed Provider Directory available to members.

The Plan is required to ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency. The Plan shall meet this requirement by having written policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that emergency medication dispensing requirements are met. These policies and procedures should describe how the Plan will monitor compliance with the requirements. The Plan did not have policies and procedures that described its procedures to monitor the provision of emergency medications in sufficient quantity.

Sacramento GMC

Category three includes requirements and procedures for processing emergency service claims and family planning service claims.

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal Fee-For-Service rate. The Plan paid non-contracted family planning services at an amount less than the Medi-Cal Fee-For-Service rate.

Category 4 – Member’s Rights

Sacramento and San Diego GMC

Category four covers procedures and requirements to establish and maintain a grievance system.

The Plan is required to address and resolve all issues presented in a member grievance. The Plan closed cases without addressing and resolving all issues presented in a member’s grievance.

Sacramento GMC

For grievances involving modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan is required to include in its written response the reasons for its determination, and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. The Plan denied clinical services that members requested through the grievance process without clearly stating the criteria, clinical guidelines, or medical policies used in reaching the determination.

Category 5 – Quality Management

Sacramento and San Diego GMC

Category five covers procedures and requirements to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers.

The Plan is required to issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding services, policies, procedures, regulations, telephone access, and special requirements regarding the Medi-Cal Managed Care program, including appeals, grievances, and State Fair Hearings. The Plan did not have a Provider Manual for Plan medical group healthcare practitioners.

Category five includes requirements to provide Medi-Cal training to staff. The Plan is required to conduct training for all providers within ten working days after placing newly contracted providers on active status. The Plan did not provide new provider training for non-physician providers within ten working days after being placed on active status.

Sacramento GMC

The Plan is required to ensure that provider training includes, but is not limited to, information on all members' rights and responsibilities. The Plan did not ensure that Medi-Cal training for new physician providers contained all contractually required members' rights information.

Category 6 – Administrative and Organizational Capacity

Sacramento and San Diego GMC

The Plan is required to conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. The Plan did not report to DHCS the results of preliminary investigations of suspected fraud and/or abuse cases within ten working days of discovery.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS, Medical Review Branch, to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

The on-site review was conducted from September 30, 2019 through October 11, 2019 at Kaiser Permanente's regional office in Oakland, California. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 24 (19 Sacramento GMC and five San Diego GMC) medical prior authorization files cases were reviewed for timeliness, consistent application of criteria, and appropriate review. No medications require prior authorization under the Kaiser Utilization Management Program.

Appeal Procedures: 19 (11 Sacramento GMC and eight San Diego GMC) appeals were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: 11 (three Sacramento GMC and eight San Diego GMC) service requests were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 14 (seven Sacramento GMC and seven San Diego GMC) medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Continuity of Care: Six (five Sacramento GMC and one San Diego GMC) medical records were reviewed to confirm continuity of care.

Non-Emergency Medical Transportation (NEMT): 50 (25 Sacramento GMC and 25 San Diego GMC) NEMT records were reviewed for appropriate adjudication.

Non-Medical Transportation (NMT): 50 (25 Sacramento GMC and 25 San Diego GMC) NMT records were reviewed for appropriate adjudication.

Category 3 – Access and Availability of Care

Claims: 32 (20 Sacramento GMC and 12 San Diego GMC) emergency services and 40 (20 Sacramento GMC and 20 San Diego GMC) family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance procedures: 94 (50 Sacramento GMC and 44 San Diego GMC) grievances, including 61 standard, 20 quality of care, and 13 expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 22 (20 Sacramento GMC and two San Diego GMC) Health Insurance Portability and Accountability Act (HIPAA)/Protected Health Information (PHI) breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Incidents (PQI): 25 (nine Sacramento GMC and 16 San Diego GMC) PQIs were reviewed for appropriate adjudication.

Provider Training: 40 (20 Sacramento GMC and 20 San Diego GMC) new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 13 (11 Sacramento GMC and two San Diego GMC) fraud and abuse cases were reviewed for processing and compliance with reporting requirements.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM DELEGATION OF UM MEDICAL DIRECTOR & MEDICAL DECISIONS
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Sacramento GMC

1.1.1 Financial Sanctions and Subcontractor Non-compliance Reporting

All Policy Letters and All Plan Letters issued by Managed Care Quality and Monitoring Division (MCQMD) and Managed Care Operations Division (MCOD) shall be complied with by the Plan. (*Contract, Exhibit E, Attachment 2 (1) (D)*)

The Plan is required to maintain policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance with the subcontract or other Medi-Cal requirements. The Plan is required to report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the Contract with DHCS to their MCOD Contract Managers within three business days of discovery or imposition. (*All Plan Letter 17-004*)

Plan policy 28 *KPNC Delegation of UM Activities for Delegated Entities*, stated any quality issues identified or corrective action plans developed will be reported to the Resource Management Committee (RMC) that result from the Plan's annual review of its delegated entities' UM Program.

Finding: The Plan did not have any policies or procedures for imposing financial sanctions on its subcontractors and delegated entities. The Plan did not have any policies or procedures for reporting significant non-compliance, imposition of corrective action, or financial sanctions of its subcontractors and delegated entities to its DHCS Contract Manager within three business days.

In an interview, the Plan stated that its written delegation agreement included the financial sanctions for non-compliance. However, the Plan did not provide any policies for imposing financial sanctions.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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When the Plan does not have any policies or procedures to impose financial sanctions on noncompliant subcontractors, the Plan cannot ensure current and future subcontractors will comply with the Contract requirements.

Recommendation: Develop and implement policies and procedures for imposing financial sanctions on subcontractors and delegated entities and reporting significant non-compliance to the Plan's DHCS Contract Manager within three business days.

Sacramento GMC

1.1.2 Communication of Subcontractor Requirements

All Policy Letters and All Plan Letters issued by Managed Care Quality and Monitoring Division and Managed Care Operations Division shall be complied with by the Plan. (Contract, Exhibit E, Attachment 2 (1) (D))

The Plan is responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, All Plan Letters. The Plan is required to maintain policies and procedures to communicate these requirements to all subcontractor and delegated entities. (*All Plan Letter 17-004*)

Plan policy *28 KPNC Delegation of UM Activities for Delegated Entities* stated the Plan's delegation agreement described the responsibilities of the Plan and the delegate, the delegated activities, and the Plan's oversight processes.

Finding: The Plan did not have policies or procedures to communicate federal, state, Contract, or DHCS requirements to its delegated entities and subcontractors.

In an interview, the Plan stated that its written delegation agreement included the delegate's requirement to follow all federal, state, Contract, and DHCS guidance. However, the Plan did not provide any policies to communicate this requirement.

When the Plan does not maintain policies and procedures to communicate the necessary requirements, the Plan cannot ensure its delegated entities and subcontractors will comply with all applicable requirements under the Contract.

Recommendation: Develop and implement policies and procedures to communicate federal, state, Contract, or DHCS requirements to its subcontractors and delegated entities.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Sacramento GMC

1.2.1 Prior Authorization requests

The Plan shall notify members of a decision to deny, defer, or modify requests for prior authorization (PA) by providing written notification. Notifications shall describe the Plan's decision and include specific regulations or Plan authorization procedures supporting the action, and appeal, and State Fair Hearing information described in state regulations. (*Contract, Exhibit A, Attachment 13 (8) (A) and (D)*)

Plan policy *RM_UM 17.00 Utilization Management Denial of Practitioner Requested Services*, stated the Plan issues a denial notice to a member whenever it denies, delays, or modifies a service requested by a practitioner based on medical necessity, benefit exclusion, or eligibility. The denial notice includes specific information about the reason for the denial and describes the appropriate appeal process.

Finding: The Plan did not notify members in writing of decisions to deny or modify prior authorization requests for out-of-plan services. A Chief Physician discussed alternate treatment options with a requesting provider who subsequently might withdraw the PA and notify the member of the decision verbally.

Plan policy, *RM_UM 4.0 Outside Services and Second Opinion, revised 8/28/18*, described the prior authorization process for out-of-network (Plan) referrals:

- A provider requested outside of network treatment.
- The Assistant Physician in Chief (APIC) reviewed the request.
- The APIC makes a coverage determination based on medical necessity.

In an interview, the Plan stated that a discussion between the Assistant Physician in Chief and requesting provider before approval or denial could result in the requesting provider withdrawing a PA and verbally notifying the member of the decision. When the Plan does not complete the PA process, the member does not receive written notice of the Plan's decision, specific regulations or Plan authorization procedures supporting the action, or appeal and State Fair Hearing rights. Although members may receive approval of the service through a subsequent grievance and then appeal process, prolonged delivery of medically necessary services may lead to adverse health effects for members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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Recommendation: Revise and implement Plan processes to ensure the completion of prior authorization requests without physician withdrawal of a prior authorization, except in instances of clear submission error or duplication, and written notification to the member of denied, delayed, or modified service requests.

San Diego GMC

1.2.1 Prior Authorization Requests

The Plan shall notify members of a decision to deny, defer, or modify requests for prior authorization (PA) by providing written notification. Notifications shall describe the Plan's decision, and include specific regulations or Plan authorization procedures supporting the action, and appeal and State Fair Hearing information described in state regulations. (*Contract, Exhibit A, Attachment 13 (8) (A) and (D)*)

Plan policy *SC.RUM.016 UM Denial of Practitioner Requested Services*, stated the Plan issues a denial notice to a member whenever it denies, delays, or modifies a service requested by a practitioner based on medical necessity, benefit exclusion, or eligibility. The denial notice includes specific information about the reason for the denial and describes the appropriate appeal process.

Finding: The Plan did not notify members in writing of decisions to deny or modify prior authorization requests for outside services. A Chief Physician discussed alternate treatment options with a requesting provider who subsequently might withdraw the prior authorization and notify the member of the decision verbally.

Plan policy, *SC_RUM.001 Consultation Referral and Second Opinion Process*, described the prior authorization process for out-of-network (Plan) referrals:

- A provider requested outside of network treatment.
- The chief of service for the requested specialty service reviewed the request.
- If the referring physician and specialist agreed that other tests, procedures, treatments, or referrals would benefit the member, the referring provider initiated an alternate plan of care and was responsible for notifying the member.
- The member could file a grievance (instead of an appeal) if they disagreed with the new plan of care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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When the Plan does not complete the prior authorization process, the member does not receive written notice of the Plan's decision, specific regulations or Plan authorization procedures supporting the action, or appeal, and State Fair Hearing rights. Although members may receive approval of the service through a subsequent grievance and then appeal process, prolonged delivery of medically necessary services may lead to adverse health effects for members.

Recommendation: Revise and implement Plan policy and processes to ensure the completion of prior authorization requests without physician withdrawal of a prior authorization, except in instances of clear submission error or duplication, and written notification to the member of denied, delayed, or modified service requests.

Sacramento GMC

1.2.2 Transplant Process

The Plan shall refer members identified as potential major organ (except for kidney) transplant candidates to a Medi-Cal approved transplant Center of Excellence (COE). If the transplant center physician considers the member to be a suitable candidate, the Plan shall submit a prior authorization request for transplantation. (*Contract, Exhibit A, Attachment 11 (18) (B)*)

Plan Policy, *RM_UM 4.0 Outside Services and Second Opinion*, stated transplant referrals are routed directly to the appropriate Plan Transplant Board Chair.

Finding: The Plan required extensive medical assessment of members before referring them for transplant evaluation at centers of excellence. The Contract did not require establishing transplant suitability, only identification as a potential candidate for transplant, before member referral to a transplant center for evaluation.

Plan policy *RM_UM 4.0 Outside Services and Second Opinion*, stated Plan physicians initiated requests for major organ transplants by entering a referral into the Plan's system of record for outside services and UM. The referral was directed to the appropriate Transplant Board Chair. The board reviewed the case, which, if approved, was referred to the COE for evaluation. The COE then made the final determination of the member's suitability for transplantation. Requesting providers received notification of denied requests for transplant evaluation by the COE.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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In response to last year's audit finding that it required detailed evaluations before COE referral and did not allow direct referral to COEs by specialists, the Plan maintained it was compliant with contractual requirements. The Plan reportedly revised policy *RM_UM 4.0 Outside Services and Second Opinion*. However, it did not submit a copy of the revised policy.

Excessive requirements may delay needed expert evaluations and organ transplantation.

This is a repeat of prior year finding 1.2.1 – Transplant Evaluation Requests.

Recommendation: Revise policies and processes to ensure the Plan refers potential transplant candidates to a Center of Excellence for evaluation without requiring testing that ensures transplant suitability.

San Diego GMC

1.2.2 Transplant Process

The Plan shall refer members identified as potential major organ (except for kidney) transplant candidates to a Medi-Cal approved transplant Center of Excellence (COE). If the transplant center physician considers the member to be a suitable candidate, the Plan shall submit a prior authorization request for transplantation. (*Contract, Exhibit A, Attachment 11 (18) (B)*)

The Plan's 2019 *UM Program Description (UMPD)*, stated Plan transplant committees reviewed cases referred for transplant evaluation using selection criteria developed through current medical literature, research, and knowledge.

Finding: The Plan required extensive medical assessment of members before referring them for transplant evaluation at Centers of Excellence. The Contract did not require establishing transplant suitability, only identification as a potential candidate for transplant, before member referral to a transplant center for evaluation.

Plan policy, *SC_RUM.001 Consultation Referral and Second Opinion Process*, stated "The COE provides the consultation and makes the final determination as to whether the member is a candidate for transplants." However, it also describes the need to complete a transplant work up checklist, and presentation to a selection committee that uses National Transplant Services Transplant Selection Criteria before approving or denying referral to a COE for evaluation. It also stated the Plan only referred a member to a COE after completion of patient "credentialing".

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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In response to last year's audit finding that it required detailed evaluations before COE referral and did not allow direct referral to COEs by specialists, the Plan maintained it was compliant with contractual requirements.

In an interview, the Plan stated it had adjusted its process:

- Some specialists could now directly refer potential transplant candidates to COEs without obtaining approval from the Plan
- Case coordinators would now expedite required pre-transplant testing

The Plan reported it has seen more rapid referral to transplant centers with new processes. However, the Plan did not submit documentation of its new processes.

Excessive requirements may delay needed expert evaluations and organ transplantation.

This is a repeat of prior year finding 1.2.1 – Transplant Evaluation Requests.

Recommendation: Revise policies and processes to ensure the Plan refers potential transplant candidates to a Center of Excellence for evaluation without requiring testing that ensures transplant suitability.

San Diego GMC

1.2.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The Plan shall provide or arrange, and pay for EPSDT services, for members under the age of 21 years. (*Contract, Exhibit A, Attachment 10 (5) (F)*)

The EPSDT benefit includes a comprehensive array of preventive, diagnostic, and treatment services. The Plan shall provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state plan unless otherwise specified in the Contract. (*All Plan Letter 18-007*)

Services that maintain (i.e., support, sustain, or prevent from worsening) the child's health condition are also covered under EPSDT because they "ameliorate" a condition. The common definition of "ameliorate" is to "make more tolerable." (*All Plan Letter 19-010 Requirements for Coverage of EPSDT Services*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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Finding: The Plan did not provide EPSDT services when medically necessary to correct or ameliorate defects.

A verification study of five prior authorizations showed the Plan denied and modified requests for continued speech therapy that met EPSDT requirements:

- In one case, the physician reviewer denied continued speech therapy stating the member was functioning at an age appropriate level. The requesting provider recommended continued treatment at the rate of one session per week for continued difficulties, maintenance, and consistency. The Plan's criteria stated therapy could be discontinued when the member reached age appropriate function, and that maintenance programs did not require the skills of a qualified provider and may not be medically necessary. The decision did not document consistency with EPSDT requirements to provide services necessary to correct or ameliorate defects.
- In another case, the Plan modified a request for two sessions a week to one. The Plan determined a member did not need intensive therapy due to his improved status. Plan criteria did not define intensive therapy, contain parameters for reducing therapy when services were still medically necessary, or show that providing services at a lesser rate met the EPSDT requirement to prevent the member's condition from worsening.
- In a third case, the Plan discontinued speech therapy due to the member reaching functional limits. The requesting provider recommended continued treatment at the rate of one session per week for continued difficulties. Plan criteria stated it could discontinue therapy when the member reached age appropriate function. The decision did not document consistency with EPSDT requirements to provide services necessary to correct or ameliorate defects.

When the Plan denies recommended and covered medically necessary treatment, members health may be negatively affected.

Recommendation: Revise Plan policy, processes, and criteria to ensure they are consistent with EPSDT criteria, and that members receive medically necessary services that meet the criteria.

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PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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1.3

PRIOR AUTHORIZATION APPEAL PROCESS

Sacramento and San Diego GMC

1.3.1 Member Appeals

If a member receives a Notice of Action (NOA), a letter informing them of a denial, deferral, or modification of service request, the member has the right to appeal. (*Contract, Exhibit A, Attachment 14 (4) (B)*)

An appeal is a review of an adverse benefit determination. A beneficiary, a provider acting on behalf of the beneficiary, or authorized representative may file an appeal. (*All Plan Letter 17-006*)

The Plan shall ensure the receipt, review, and resolution of grievances and appeals. (*All Plan Letter 17-006*)

A delegation of responsibilities matrix indicated the Plan did not delegate appeal resolution to any non-Plan entities.

Delegate policy, *CA UM 4 Member Appeals and Grievances – California – Medi-Cal*, stated the delegate would forward all member appeals to the Plan.

Delegate policy, *CA UM 5 Provider and Practitioner Appeals and Grievances* stated if a provider appealed an adverse benefit decision on behalf of a member with the latter's written consent, the delegate forwarded the case to the Plan for resolution.

Finding: The Plan did not ensure the receipt, review, and resolution of all member appeals. A delegate's policy allowed processing appeals as provider appeals, if the requesting provider did not indicate he/she was acting on behalf of a Plan GMC member, even when the appeal concerned a pre-service denial.

The delegate's website stated providers could appeal any non-approved or partially approved service, or any non-payment of a claim. It directed them to the member portal for an appeal form if they were appealing on the member's behalf. The member portal did not contain appeal forms.

In an interview, the delegate stated providers needed to stipulate on appeal forms when they were appealing on members behalf. If they did not, the delegate resolved the appeals internally as provider appeals instead of referring them to the Plan for resolution.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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In a separate interview, the Plan stated it was aware the delegate processed provider appeals about adverse benefit decisions when the provider was not appealing on the member's behalf.

Labeling and processing appeals of service denials as provider rather than as member appeals by a delegate may deprive members of their full appeal rights, including presenting information during appeal hearings and filing for State Fair Hearing; the Plan may not receive all appeals it is responsible for adjudicating.

Recommendation: Implement policies and processes that ensure the appropriate identification and forwarding of all member appeals from delegates.

Sacramento GMC

1.3.2 Appeals of Non-covered Benefits

The Plan shall ensure that a health care professional with appropriate clinical expertise in treating the member's condition or disease shall resolve an appeal that involves clinical issues. (*Contract, Exhibit A, Attachment 14 (2) (D) and APL 17-006*)

Plan policy, *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues*, stated appropriate individuals would review issues presented in the appeal; at least one practitioner practicing in the same or a similar specialty would review clinical issues. For cases involving benefit and/or contractual determinations, a non-physician management staff could make the determination.

Finding: The Plan did not ensure health care professionals with clinical expertise decided appeals. Non-clinical staff resolved appeals containing clinical issues, and which were for services the Plan had previously denied for not a covered benefit.

A verification study showed non-clinicians resolved appeals with clinical issues in four of 11 appeals reviewed:

- In one case, non-clinical staff denied the oximeter requested by a member with respiratory failure. A reviewing clinician stated the item was medically necessary but non-clinicians made the final unfavorable decision.
- In another case, non-clinical staff denied gloves and wipes on appeal for an incontinent member. There was no medical necessity review.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

The above appeals resulted from denials issued by non-clinical Plan staff because the items were not covered benefits. Appeals of these denials were requests for reconsideration of the denials due to the health needs of the appealing members. Therefore, these appeals required resolution by a qualified clinician.

In an interview, the Plan stated it determined appeals on a case-by-case basis.

When treating clinicians do not resolve appeals with clinical components, the Plan may deny medically necessary services with resultant adverse health effects.

Recommendation: Revise and implement Plan policy and processes to ensure that qualified treating healthcare professionals resolve all appeals that include clinical issues.

San Diego GMC

1.3.2 Appeals of Non-covered Benefits

The Plan shall ensure that a health care professional with appropriate clinical expertise in treating the member's condition or disease shall resolve an appeal that involves clinical issues. (*Contract, Exhibit A, Attachment 14 (2) (D) and All Plan Letter 17-006*)

Plan policy, *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues*, stated appropriate individuals would review issues presented in the appeal; at least one practitioner practicing in the same or a similar specialty would review clinical issues. For cases involving benefit and/or contractual determinations, a non-physician management staff may make the determination.

Finding: The Plan did not ensure health care professionals with clinical expertise decided appeals. Non-clinical staff resolved appeals containing clinical issues, and which were for services the Plan had previously denied for not a covered benefit.

A verification study showed non-clinicians resolved appeals with clinical issues in one of eight appeals reviewed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan allowed non-clinical staff to decide appeals of services denied as not a covered benefit. In one case, non-clinical staff denied payment for a fully electric bed without medical necessity review. The member appealed charges for a fully electric hospital bed, which is not a covered benefit. However, the member may have been provided this item in error as the original doctor's order was for a semi-electric, full size bed for a 400-pound patient, which is a covered benefit. No physician determined the medical necessity for the item or commented on the original error.

The above appeal resulted from a denial issued by non-clinical Plan staff because the item was not a covered benefit. The appeal was a request for reconsideration due to the health needs of the appealing member. Therefore, this appeal required resolution by a qualified clinician.

In an interview, the Plan stated it determined appeals on a case-by-case basis.

When treating clinicians do not resolve appeals with clinical components, the Plan may deny medically necessary services with resultant adverse health effects.

Recommendation: Revise and implement Plan policy and processes to ensure that qualified treating healthcare professionals resolve all appeals that include clinical issues.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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DATE OF AUDIT: September 30, 2019 to October 11, 2019

1.4

MENTAL HEALTH AND SUBSTANCE ABUSE

Sacramento GMC

1.4.1 Primary Care Outpatient Mental Health Services

The Plan is required to cover outpatient mental health services that are within the scope of practice of primary care physicians. The Plan is required to maintain policies and procedures that define and describe what services are to be provided by primary care providers. (*Contract, Exhibit A, Attachment 10 (8) (E) (1)*)

The Plan's, *Behavioral Health Program Description*, states members can consult with their primary care physicians who are trained to diagnose and treat some behavioral health conditions. Primary care physicians can consult with behavioral health practitioners on an as-needed basis for members with co-morbid conditions. The Plan's program description does not identify what mental health services primary care providers may perform.

Finding: The Plan did not maintain policies and procedures that define and describe what services are to be provided by primary care physicians in regards to outpatient mental health services.

In an interview, the Plan confirmed that it did not have any policies or procedures that define primary care physician outpatient mental health services.

When the Plan does not maintain policies and procedures that define and describe what mental health services primary care providers can perform, it cannot ensure its practitioners provide outpatient mental health services.

Recommendation: Develop and implement policies and procedures that define and describe what outpatient mental health services are provided by primary care physicians.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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San Diego GMC

1.4.1 Primary Care Outpatient Mental Health Services

The Plan is required to cover outpatient mental health services that are within the scope of practice of primary care physicians. The Plan is required to maintain policies and procedures that define and describe what services are to be provided by primary care physicians. (*Contract, Exhibit A, Attachment 10 (4) (F)*)

The Plan's, *Behavioral Health Program Description*, states primary care providers who may be treating co-morbid behavioral disorders along with medical disorders can obtain telephone consultations with behavioral practitioners.

Finding: The Plan did not maintain policies and procedures that define and describe what services are to be provided by primary care physicians in regards to outpatient mental health services.

The Plan stated the role of primary care providers with regard to mental health and substance abuse services is defined in the *Behavioral Health Program Description*. The Plan referenced a portion of its program description that discussed chemical dependency, substance use disorder, and mental health service covered services. *The Behavioral Health Program Description* did not define which practitioners can perform these services.

When the Plan does not maintain policies and procedures that define and describe what mental health services primary care providers can perform, it cannot ensure its practitioners provide outpatient mental health services.

Recommendation: Develop and implement policies and procedures that define and describe what outpatient mental health services are provided by primary care physicians.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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Sacramento GMC

1.4.2 Specialty Mental Health Services

The Plan is required to develop and implement a written internal policy and procedure to ensure members who need specialty mental health services (services outside the scope of practice of primary care provider) are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service mental health provider or to the county mental health plan for specialty mental health services. (*Contract, Exhibit A, Attachment 10 (8) (E) (3)*)

Finding: The Plan did not maintain policies and procedures that ensure member referral to specialty mental health services with an appropriate mental health provider or the county mental health plan.

The Plan stated its physicians and psychiatrists will refer members for specialty mental health services with the county mental health plan (MHP) when those services are not available or covered under the Plan's Contract. The Plan did not provide any documentation describing its referral process.

When the Plan does not maintain policies and procedures that ensure member referral to specialty mental health services, the Plan cannot ensure members are referred to the appropriate level of care.

Recommendation: Develop and implement policies and procedures that ensure member referral to specialty mental health services with an appropriate mental health provider or the county mental health plan.

San Diego GMC

1.4.2 Specialty Mental Health Services

The Plan is required to develop and implement a written internal policy and procedure to ensure members who need specialty mental health services (services outside the scope of practice of primary care physicians, are referred to and are provided mental health services by an appropriate an appropriate Medi-Cal Fee-For-Service mental health provider or to the county mental health plan for specialty mental health services. (*Contract, Exhibit A, Attachment 10 (7) (D) (3)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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Finding: The Plan did not maintain policies and procedures that ensure member referral to specialty mental health services with an appropriate mental health provider or the county mental health plan.

The Plan stated members are referred to the Plan's Behavioral Health department for an assessment to determine if a member meets criteria for specialty mental health services with the county mental health plan (MHP). If a member does meet the criteria, a behavioral health staff would coordinate with the member and the county MHP to schedule an intake appointment. The Plan did not provide any documentation describing its referral process.

When the Plan does not maintain policies and procedures that ensure member referral to specialty mental health services, the Plan cannot ensure members are referred to the appropriate level of care.

Recommendation: Develop and implement policies and procedures that ensure member referral to specialty mental health services with an appropriate mental health provider or the county mental health plan.

Sacramento GMC

1.4.3 Evidence of Coverage

The Evidence of Coverage is required to include a description of the full scope of Medi-Cal Managed Care benefits, all available services, and "carve out" services; including an explanation of any services limitations and exclusions from coverage. (*Contract, Exhibit A, Attachment 13 (4) (D) (2)*)

The Plan is responsible for providing outpatient mental health services to members of mild to moderate impairment in functioning. The Plan is required to coordinate and refer members with significant impairments in functioning to county mental health plans for delivery of specialty mental health services, including, but not limited to intensive care coordination, intensive home based services, and therapeutic foster care services. (*All Plan Letter 17-018*)

Finding: The Plan did not inform members of all carved out services available to members that are not covered by the Plan) specialty mental health services. The Plan's Evidence of Coverage (EOC) document did not inform members of the availability of intensive care coordination, intensive home based services, and therapeutic foster care services through the county.

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The Plan stated that these services were the responsibility of the county mental health plan; therefore, the Plan omitted them from the EOC. The Plan further stated that it specifically notified DHCS that these services were omitted. The Plan stated it assumed with DHCS's approval of the EOC with the changes, that DHCS agreed that the Contract did not impose the coverage of these services on the Plan.

When the Plan does not inform members of all carved out specialty mental health services, members may face barriers in accessing needed care.

Recommendation: Inform members of covered services as well as of any service limitations and exclusions from coverage to ensure member notification of all carved out specialty mental health services.

San Diego GMC

1.4.4 Alcohol Misuse Screenings

All Policy Letters and All Plan Letters issued by Managed Care Quality and Monitoring Division and Managed Care Operations Division shall be complied with by the Plan. (*Contract, Exhibit E, Attachment 2 (1) (D)*)

The Plan is required to maintain policies and procedures to ensure that providers in primary care settings offer and document alcohol misuse screening services. (*All Plan Letter 18-014*)

Finding: The Plan did not maintain policies that ensure that providers in primary care settings offer and document alcohol misuse screening services.

The Plan stated its electronic medical record system contains processes, tools, and workflows for screening substance abuse disorders. Its electronic medical record system alerts primary care providers to conduct alcohol or depression screenings. The system provides primary care providers its instructions and criteria to use when conducting the screenings. The Plan has a system in place to ensure primary care providers conduct alcohol misuse screenings; however, the Plan did not provide any policies.

When the Plan does not maintain policies, it is not in compliance with the Contract.

Recommendation: Develop and implement policies to ensure that providers in primary care settings offer and document alcohol misuse screening services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	NON-MEDICAL TRANSPORTATION AND NON-EMERGENCY MEDICAL TRANSPORTATION
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Sacramento GMC

2.4.1 Physician Certification Statement (PCS)

The Contract included non-emergency medical transportation as part of “Medically Necessary Covered Services for the member.” (*Contract, Exhibit A, Attachment 10 (2) (e)*)

Plans are required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. All Non-Emergency Medical Transportation (NEMT) PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member’s ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and physician certification statement of medical necessity. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. (*All Plan Letter 17-010*)

The Plan’s *Medi-Cal Transportation* policy required the use of DHCS-approved PCS forms.

Finding: The Plan did not use a DHCS-approved Physician Certification Statement (PCS) form or have a mechanism to capture and submit data from the PCS form. Transportation records did not contain physical and medical limitations of members, dates of service needed, mode of transportation, or a physician certification statement of medical necessity.

A verification study revealed 25 of 25 NEMT service requests did not include the use of a PCS form or any of the required components.

During an interview, the Plan reported that all required information was contained in its electronic transportation system. However, the verification study confirmed that requests for transportation services did not include any of the required components.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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Subsequent to the Exit Conference, the Plan submitted additional information. The Plan stated that Plan physicians or providers pre-authorize NEMT requests. APL 17-010 requires the Plan, not Plan physicians or providers, to authorize at minimum the lowest cost type NEMT transportation that is adequate for the member's medical needs.

Review of the Plan's transportation system's data elements did not contain the required PCS information. The Plan stated it had a field for physical or medical limitations, dates of services needed, and mode of transportation; however, the Plan did not provide documentation to demonstrate this information was captured.

The Plan also stated its transportation system determines if medical necessity for transportation is met. APL 17-010 requires a physician statement certifying that medical necessity was used to determine the type of transportation requested. The Plan's processes did not require a physician certification for NEMT requests.

Without the use of a DHCS-approved PCS form to capture all required PCS information, the Plan cannot ensure that NEMT requests contain all elements required to determine medical necessity.

Recommendation: Implement and maintain the use of a DHCS-approved PCS form to capture all required information for NEMT requests.

San Diego GMC

2.4.1 Physician Certification Statement (PCS)

The Contract included non-emergency medical transportation as part of "Medically Necessary Covered Services for the Member." (*Contract, Exhibit A, Attachment 10 (2) (e)*)

Plans are required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. All Non-Emergency Medical Transportation (NEMT) PCS forms must include, at a minimum, the following components: documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and physician certification statement of medical necessity. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. (*All Plan Letter 17-010*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan's, *Medi-Cal Transportation*, policy required the use of DHCS-approved PCS forms.

Finding: The Plan did not use a DHCS-approved Physician Certification Statement (PCS) form or have a mechanism to capture and submit data from the PCS form. Transportation records did not contain physical and medical limitations of members, dates of service needed, mode of transportation, or a physician certification statement of medical necessity.

A verification study revealed 25 of 25 NEMT service requests that did not include the use of a PCS form or any of the required components.

During an interview, the Plan reported that all required information was contained in its electronic transportation system. However, the verification study confirmed that requests for transportation services did not include any of the required components.

Subsequent to the Exit Conference, the Plan submitted additional information. The Plan stated that Plan physicians or providers pre-authorize NEMT requests. APL 17-010 requires the Plan, not Plan physicians or providers, to authorize at minimum the lowest cost type NEMT transportation that is adequate for the member's medical needs.

Review of the Plan's transportation system's data elements did not contain the required PCS information. The Plan stated it had a field for physical or medical limitations, dates of services needed, and mode of transportation; however, the Plan did not provide documentation to demonstrate this information was captured.

The Plan also stated its transportation system determines if medical necessity for transportation is met. APL 17-010 requires a physician statement certifying that medical necessity was used to determine the type of transportation requested. The Plan's processes did not require a physician certification for NEMT requests.

Without the use of a DHCS-approved PCS form to capture the PCS information, the Plan cannot ensure that NEMT requests contain all elements required to determine medical necessity.

Recommendation: Implement and maintain the use of a DHCS-approved PCS form to capture all required information for NEMT requests.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES
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Sacramento and San Diego GMC

3.1.1 Printed Provider Directory

The Plan is required to ensure that all written member information is provided to members at a sixth grade reading level or as determined appropriate through the Plan's group needs assessment and approved by DHCS. (*Contract, Exhibit A, Attachment 13 (4) (C)*)

A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the Provider Directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. (*Health & Safety Code, Section 1367.27*)

Finding: The Plan did not maintain a DHCS approved printed Provider Directory available to members.

The prior three DHCS audits found that the Plan did not maintain a Provider Directory. The Plan maintained a separate Guidebook for each service area informing members of Plan owned medical centers, medical offices, and specialty facilities, in addition to contracted physicians. The Guidebook did not contain any provider information.

The Plan had developed a draft Provider Directory, which included contracted and Plan employed physicians. However, the draft Provider Directory had not been approved by DHCS.

If the Plan does not provide members with a printed Provider Directory, members without internet access would not be able to find the full network of providers that are available to them.

This is a repeat of prior year finding 3.1.1 – Printed Provider Directory

Recommendation: Develop and implement a complete DHCS approved Provider Directory in print for members upon request.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Sacramento GMC

3.3.1 Family Planning Claims

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal Fee-For-Service rate. (*Contract, Exhibit A, Attachment 8 (9)*)

The Plan's, *National Claims Administration Medi-Cal Management Guide*, states Medi-Cal reimburses non-contracted family planning providers at no less than the appropriate Medi-Cal rate.

Finding: The Plan paid non-contracted family planning claims at an amount less than the Medi-Cal Fee-For-Service rate. The Plan inappropriately denied family planning claims when diagnosis codes associated with family planning claims were not found in the Plan's claim system.

A verification study revealed two of 20 family planning claims were not paid at the appropriate Medi-Cal Fee-For-Service rate. The Plan denied two family planning claims with service code 81025, urine pregnancy test, because the associated diagnosis codes were not set in the Plan's fee schedule.

The prior DHCS audit found that the Plan paid family planning claims at rate of \$0 or denied the claims, because the service codes were not set in the claims system (3.3.1 – Family Planning Claims). As a corrective action, the Plan updated its fee schedule to pay family planning services as the appropriate Medi-Cal Fee-For-Service rates and implemented a control report to monitor accurate payment to non-contracted family planning providers.

In an interview, the Plan reported its corrective actions for the prior year's finding did not include configuration of some family planning diagnosis in its fee schedule. As a result, the Plan's claims systems is set to deny family planning claims with these missing diagnosis codes.

Inappropriate denials and reimbursements of family planning claims may limit members' access to care and discourage providers from participating with the Plan if not properly reimbursed.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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This is a repeat of prior year finding 3.3.1 – Family Planning Claims.

Recommendation: Develop and implement procedures to ensure appropriate adjudication of non-contracted family planning claims.

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PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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3.4

ACCESS TO PHARMACEUTICAL SERVICES

Sacramento and San Diego GMC

3.4.1 Monitoring Emergency Medication Supply

The Plan shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency. The Plan shall meet this requirement by having written policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that emergency medication dispensing requirements are met. These policies and procedures should describe how the Plan will monitor compliance with the requirements. (*Contract, Exhibit A, Attachment 10, 8 (G) (1) (a)*)

Plan policy, *CA PHARM 3.0.11 Emergency Refill*, stated a pharmacist can refill a prescription if a prescriber is unavailable to authorize a refill and the prescription is refillable and emergent.

Finding: The Plan did not have policies and procedures that described its procedures to monitor the provision of emergency medications in sufficient quantity.

In response to a DHCS questionnaire, the Plan reported it did not monitor medication dispensed in an emergency.

When Plan does not have written emergency medication supply policies and procedures in place, it cannot ensure that members can access sufficient quantities of medication during an emergency.

Recommendation: Develop and implement policies and procedures to ensure access to at least a 72-hour supply of a covered drug in an emergency.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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Sacramento GMC

4.1.1 Grievance Resolution

The Plan shall resolve grievances as described in California Code of Regulations, Title 28, 1300.68. (*Contract, Exhibit A, Attachment 14 (1)*)

A grievance is an expression of dissatisfaction. The Plan shall resolve grievances within 30 calendar days of receipt, where resolved means the Plan has reached a conclusion with respect to the enrollee’s submitted grievance. (*California Code of Regulations, Title 28, Section 1300.68*)

The Plan shall address and resolve all issues presented in a member grievance. The Plan is required to investigate all member complaints and resolve all member complaints. (*All Plan Letter 17-006*)

Plan policy *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues*, stated to the extent possible, the Plan facilitates a complete resolution to the member’s concern and/or requests. Member services directed potential quality of care grievances to the Medical Director for review and decisions.

Finding: The Plan closed cases without addressing and resolving all issues in a member’s grievance. The Plan did not investigate or only partially investigated and resolved grievances.

A verification study revealed deficiencies in 12 of 43 cases:

- In five quality of service cases, Plan closed grievances after forwarding the member’s complaint to the respective department without any investigation within the grievance system. The complaints ranged from cancelling appointment without member’s knowledge, incorrect diagnosis, to provider’s inappropriate behavior.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- In seven quality of care cases, grievances were not completely resolved:
 - A healthcare professional qualified to treat disease did not resolve the case in question. A resolution letter described the Plan's resolution as sending a notice about the complaint to a department supervisor.
 - Reviewer did not resolve why a hearing defect went undetected or not reported for over nine years.

In the corrective action plan to the prior audit deficiency (4.1.1 Grievance Resolution, for not investigating and resolving grievances, the Plan did not address the deficiency. While acknowledging that some cases needed more investigation, the Plan's corrective action was to provide refresher training on clear and concise resolution letters, rather than on investigating the complaints. For other cases, the Plan stated that it was neither appropriate nor value-added to include confidential information in the resolution letters to members.

Grievance resolution does not require disclosure of confidential information; however, resolutions must include a description of the Plan's investigation and proposed resolution.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

This is a repeat of prior year finding 4.1.1 – Grievance Resolution.

Recommendation: Revise and implement Plan policy and processes to completely resolve member grievances.

San Diego GMC

4.1.1 Grievance Resolution

The Plan shall resolve grievances as described in CCR, Title 28, 1300.68. (*Contract, Exhibit A, Attachment 14 (1)*)

A grievance is an expression of dissatisfaction. The Plan shall resolve grievances within 30 calendar days of receipt, where resolved means the Plan has reached a conclusion with respect to the enrollee's submitted grievance. (*California Code of Regulations, Title 28, Section 1300.68*)

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The Plan shall address and resolve all issues presented in a member grievance. (*All Plan Letter 17-006, (VII) (E)*)

Plan policy, *50-2M Grievance, Initial Determination and Appeal Process for Resolution of Managed Medi-Cal Member Issues*, stated to the extent possible, the Plan facilitates a complete resolution to the member's concern and/or requests. Member services directed potential quality of care grievances to the Medical Director for review and decisions.

Finding: The Plan closed cases without investigating and resolving all issues in a member's grievance. The Plan did not investigate or only partially investigated and resolved grievances.

A verification study revealed deficiencies in seven of 38 cases:

- In two quality of service grievances, members' complains include inadequate treatment by physicians or poor care experience by nurses. Plan closed the cases after forwarding the complaints to the respective department without any investigation within the grievance system.
- In another quality of service case, a member complained about poor services by two physicians. This member also requested a back brace for her chronic back pain. Plan investigated and denied the request of back brace because it was not medically necessary. Plan closed the cases after forwarding the complaints to the supervisory clinicians without any investigation within the grievance system.
- In four quality of care grievances, a healthcare professional qualified to treat the disease did not resolve the four cases in question. Resolution letters described the Plan's resolution as sending notices about the complaints to department supervisors.

In the corrective action plan to the prior audit deficiency, 4.1.1 Grievance Resolution, for not investigating and resolving grievances, the Plan did not address the deficiency. While acknowledging that some cases needed more investigation, the Plan's corrective action was to provide refresher training on clear and concise resolution letters, rather than on investigating the complaints. For other cases, the Plan stated that it was neither appropriate nor value-added to include confidential information in the resolution letters to members.

Grievance resolution does not require disclosure of confidential information; however, resolutions must include a description of the Plan's investigation and proposed resolution.

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Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

This is a repeat of prior year finding 4.1.1 – Grievance Resolution.

Recommendation: Revise and implement Plan policy and processes to completely resolve member grievances.

Sacramento GMC

4.1.2 Grievance Resolution Criteria

Contractor shall implement and maintain a Member grievance system in accordance with CCR, Title 28, 1300.68. (*Contract, Exhibit A, Attachment 14 (1)*)

For grievances involving modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan shall include in its written response, the reasons for its determination, and clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. (*California Code of Regulations, Title 28, section 1300.68*)

Plan policy *50-2M Grievance, Initial Determination, and Appeal Process for Resolution of Managed Medi-Cal Member Issues*, defined initial determinations as member requests for services submitted as part of an expression of dissatisfaction (grievance). It stated the Plan described the criteria, the clinical reasons, medical policies, or clinical judgment used for any denials of member requested services.

Finding: The Plan denied clinical services that members requested through the grievance process without clearly stating the criteria, clinical guidelines, or medical policies used in reaching the determination.

A verification study showed deficiencies in citing criteria, clinical guidelines and medical policies for the Plan's denial decisions in three of 12 quality of care grievances:

- The Plan denied speech therapy for a member stating it was not medically indicated based on medical expert opinion and committee review. The decision-makers stated the member needed a new assessment for therapy as the last evaluation was 6 months old, but did not cite the guidelines that recommended this periodic assessment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- The Plan denied play therapy for a member because it was not evidence based. The decision-maker did not cite criteria or clinical guidelines upon which the determination was based.
- The Plan denied out-of-network psychiatric care due to multiple missed in-plan appointments. The Plan did not cite the policy that required members to exhaust in-plan treatment before they could qualify for out-of-plan care. The decision makers stated they based their recommendation on medical expert opinion and committee review.

In interviews, the Plan reported that it did not have set criteria for grievance decisions.

When the Plan does not cite criteria for its decisions that clinical services are not medically indicated, the basis for denials is unclear.

Recommendation: Revise Plan policy, and develop and implement processes to include the criteria, clinical guidelines, and medical policies utilized for the Plan's grievance decisions that services are not medically indicated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM

DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Sacramento GMC

5.1.1 Quality Program Description

The written description of the Plan's Quality Improvement System shall include qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training. (*Contract, Exhibit A, Attachment 4 (7) (C)*)

Attachment C of the Plan's, *2018 Quality Program Description (QPD)*, listed the organizational titles and activities of key Plan quality leaders. Attachment A of the 2019 Quality Program Description listed Northern California Quality leaders.

Finding: The written description of the Plan's Quality Improvement System did not include qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training.

The 2018 QPD listed the organizational titles of key quality leaders and their duties, but did not describe qualifications for the positions. The Regional Quality Oversight Committee (QOC) charter in the QPD listed the organizational titles of committee members but no qualifications for the positions.

The 2019 QPD listed two individuals as key Northern California Quality leaders and their organizational titles, but did not describe their qualifications. The QPD listed the Chairs and members of the QOC and their organizational titles, but not their qualifications. The GMC-QOC charter did not list current members or their qualifications. A Plan document listed the current members of the GMC-QOC, but not their qualifications.

Listing the qualifications of staff responsible for quality improvement confirms/supports the Plan's commitment to ensure the provision of high value health care services through the employment of qualified individuals.

Recommendation: Include qualifications of staff responsible for quality improvement studies and activities in the QPD.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

San Diego GMC

5.1.1 Quality Program Description

The written description of the Plan's Quality Improvement System (QIS) shall include qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training. (*Contract, Exhibit A, Attachment 4 (7) (C)*)

The 2019 Quality Program Description stated that the Southern California Quality Committee (SCQC) is comprised of physicians, clinical, and quality leaders.

Finding: The written description of the Plan's QIS did not include qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training.

The Plan's 2019 QPD listed the members of the SCQC and their organizational titles, but not their qualifications. The San Diego Medi-Cal Committee charter listed the group's current members, but not their qualifications.

Listing the qualifications of staff responsible for QI confirms/supports the Plan's commitment to ensure the provision of high value health care services through the employment of qualified individuals.

Recommendation: Include qualifications of staff responsible for QI studies and activities in the QPD.

Sacramento GMC

5.1.2 Provider Manual

The Plan shall maintain and implement appropriate procedures to keep contracting providers informed of the written Quality Improvement Systems (QIS, its activities, and outcomes. (*Contract, Exhibit A, Attachment 4 (5)*)

The Plan shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding services, policies, procedures, regulations, telephone access, and special requirements regarding the Medi-Cal Managed Care program, including appeals, grievances, and State Fair Hearings. (*Contract, Exhibit A, Attachment 7 (4)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

The Plan's *Annual TPMG (The Permanente Medical Group) Practitioner Communication, Quality and UM Policies*, for the Plan's medical group stated the letter was a reference tool that communicated aspects of its QI and UM programs.

Finding: The Plan did not have a Provider Manual for its medical group that served as a provider resource for Medi-Cal managed care services, policies and procedures, regulations and special requirements.

The Plan's 2019 TPMG provider communication letter did not inform TPMG practitioners of Medi-Cal specific services, policies and procedures, statutes, regulations, telephone access, appeals, grievances, State Fair Hearings, and special requirements regarding the Medi-Cal Managed Care Program.

The Plan's, *2019 Northern California HMO Provider Manual*, for non-Kaiser doctors who contracted with the Plan did not comprehensively inform HMO providers about Medi-Cal managed care services, policies and procedures, regulations, and special requirements.

In response to last year's DHCS audit finding that the Plan did not have a Provider Manual, the Plan responded that a manual was in process of development. The Plan however, did not produce a draft manual during the current audit.

Without a comprehensive resource and updates containing information about Medi-Cal specific policies, procedures, requirements, and benefits, TPMG practitioners may be misinformed and may not provide members with medically necessary covered services.

This is a repeat of prior year finding 5.1.5 – Provider Manual.

Recommendation: Develop and implement a Provider Manual that informs TPMG health care practitioners about the Medi-Cal Managed Care program.

San Diego GMC

5.1.2 Provider Manual

The Plan shall maintain and implement appropriate procedures to keep contracting Providers informed of the written Quality Improvement Systems (QIS), its activities, and outcomes. (*Contract, Exhibit A, Attachment 4 (5)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

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The Plan shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding policies and procedures, statutes, regulations, telephone access, and special requirements regarding the Medi-Cal Managed Care program. (*Contract, Exhibit A, Attachment 7 (4)*)

The Plan's, 2018-2019 Annual *SCPMG (Southern California Permanente Medical Group) Practitioner Communication*, stated the letter annually communicated to all employees, providers, and practitioners the Plans policies, processes, and practices. The letter updated both contracted and the Plan medical group providers about Medi-Cal managed care changes.

Finding: The Plan did not have a Provider Manual for Plan medical group healthcare practitioners.

In response to last year's DHCS audit finding that the Plan did not have a Provider Manual, the Plan responded that a manual was in process of development. The Plan however, did not produce a draft manual during the current audit.

Without a comprehensive resource manual containing information about Medi-Cal specific policies, procedures, requirements, and benefits, SCPMG practitioners may be misinformed and may not provide members with medically necessary covered services.

This is a repeat of prior year finding 5.1.5 – Provider Manual.

Recommendation: Develop and implement a Provider Manual that informs SCPMG health care practitioners about the Medi-Cal Managed Care program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

5.2

PROVIDER QUALIFICATIONS

Sacramento GMC

5.2.1 Training for Newly Contracted Non-Physician Providers

The Plan is required to conduct training for all new non-physician providers within ten working days after the Plan places a newly contracted provider on active status.

(Contract, Exhibit A, Attachment 7 (5) (A))

The Contract defines a provider as a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services to members. *(Contract, Exhibit E, Attachment 1, Definitions)*

Plan policy, *NATL.HR.012 Compliance Training Policy*, stated new non-physician providers must complete Medi-Cal compliance training within ten days of hire.

Finding: The Plan did not ensure Medi-Cal training was conducted for new non-physician providers within ten working days of active status with the Plan.

A verification study revealed ten of ten non-physician providers hired between September 2018 and June 2019 did not complete training within ten working days. The time elapsed between hire dates and training completion ranged from 21 working days to 192 working days.

The Plan cannot ensure non-physician providers operate in full compliance with the Contract and applicable regulations without new provider training. If the Plan does not ensure new provider training is completed within ten working days, it cannot ensure that providers will be compliant with contractual requirements.

This is a repeat of prior year finding 5.2.1 – Training for Newly Contracted Non-Physician Providers.

Recommendation: Ensure all new non-physician providers receive new provider training with ten working days after the Plan places a newly contracted provider on active status.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

San Diego GMC

5.2.1 Training for Newly Contracted Non-Physician Providers

The Plan is required to conduct training for all new non-physician providers within ten working days after the Plan places a newly contracted provider on active status. (*Contract, Exhibit A, Attachment 7 (5) (A)*)

The Contract defines a provider as a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services to members. (*Contract, Exhibit E, Attachment 1, Definitions*)

Plan policy, *NATL.HR.012 Compliance Training Policy*, stated new non-physician providers must complete Medi-Cal compliance training within ten days of hire.

Finding: The Plan did not ensure Medi-Cal training was conducted for new non-physician providers within ten working days of active status with the Plan.

A verification study of ten samples revealed ten non-physician providers hired between September 2018 and June 2019 did not complete training within ten working days. The time elapsed between hire dates and training completion ranged from 14 working days to 205 working days.

The Plan cannot ensure non-physician providers operate in full compliance with the Contract and applicable regulations without new provider training. If the Plan does not ensure new provider training is completed within ten working days, it cannot ensure that providers will be compliant with contractual requirements.

This is a repeat of prior year finding 5.2.1 – Training for Newly Contracted Non-Physician Providers.

Recommendation: Ensure all new non-physician providers receive new provider training within ten working days after the Plan places a newly contracted provider on active status.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

Sacramento GMC

5.2.2 Training Material for Newly Contracted Physician Providers

The Plan is required to ensure that provider training includes, but is not limited to, information on all member rights and responsibilities. The Contract identifies the member rights and responsibilities that are required in the Plan's policies and training material, including but not limited to, Medi-Cal State Fair Hearing information. (*Contract, Exhibit A, Attachment 7 (5) (A)) and Attachment 13 (1) (A) (1)*)

Plan policy, *NATL.HR.012 Compliance Training Policy*, required the Plan's providers to complete all designated compliance training courses within identified course completion timeframes and deadlines, pursuant to the Ethics and Compliance Training Standards.

Finding: The Plan did not ensure Medi-Cal training for new physician providers contained all required training material as required by the Contract.

In the verification study, ten of ten physician providers hired between September 2018 and June 2019 did not receive all member rights and responsibilities Medi-Cal training as stipulated by the Contract. Specifically, the Plan did not provide training material on a member's right to request a Medi-Cal State Fair Hearing, including information on the circumstances under which an expedited fair hearing is possible.

If the Plan does not ensure that providers receive all required training, it cannot ensure that providers will be compliant with contractual requirements.

Recommendation: Ensure all new physician providers receive complete training materials as stipulated in the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

DATE OF AUDIT: September 30, 2019 to October 11, 2019

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE
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Sacramento and San Diego GMC

6.2.1 Preliminary Investigation

The Plan shall conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. (*Contract, Exhibit E, Attachment 2 (25) (B) (4)*)

Plan policy *NATL.NCO.011, National Fraud, Waste, and Abuse Control*, stated the Plan is committed to complying with all laws and regulations associated with the control of fraud, waste, and abuse.

The Plan's, *Medi-Cal Fraud Referral Reporting Process*, document outlined steps on reporting Initial 609 forms to DHCS as part of the investigation process.

Finding: The Plan did not report to DHCS the results of a preliminary investigation of suspected fraud and/or abuse cases within ten working days of discovery.

A verification study revealed six of 13 cases reported to DHCS within ten working days of discovery did not have evidence of a preliminary investigation.

By not reporting the results of a preliminary investigation, the Plan is out of compliance with the Contract.

Recommendation: Ensure preliminary investigations are reported to DHCS within ten working days of discovery.

MEDICAL REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

Contract Number: 07-65850 Sacramento
09-86160 San Diego

State Supported Services

Audit Period: September 1, 2018
Through
August 31, 2019

Report Issued: January 17, 2020

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INTRODUCTION

This report presents the audit findings of KP Cal, LLC State Supported Services Contract No. 07-65850 for Sacramento GMC and Contract No. 09-86160 for San Diego GMC. The State Supported Services Contracts cover contracted abortion services.

The onsite review was conducted from September 30 through October 11, 2019. The audit period was September 1, 2018 through August 31, 2019 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

24 (12 Sacramento GMC and 12 San Diego GMC) State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: KP Cal, LLC – Kaiser Permanente Sacramento and San Diego GMC

AUDIT PERIOD: September 1, 2018 to August 31, 2019

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes: 59840 through 59857*

HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING(S):

There were no deficiencies identified in the current audit.

RECOMMENDATION(S):

None