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

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

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

AND

Kaiser Foundation Health Plan Inc.
LI and COHS Subcontracts

Plan Partners: Alameda Alliance for Health
CalViva Health
Contra Costa Health Plan
Health Plan of San Joaquin
Health Plan of San Mateo
Partnership Health Plan of California
San Francisco Health Plan
Santa Clara Family Health Plan
CalOptima
Gold Coast Health Plan
Inland Empire Health Plan
Kern Family Health Plan
L.A. Care Health Plan

Audit Period: September 1, 2015
Through
August 31, 2016

Report Issued: March 2, 2017

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I. INTRODUCTION

Direct GMC Contracts

Kaiser Foundation Health Plan, Inc. (KFHP) obtained its Knox-Keene license in November 1977 and contracted with the Department of Health Care Services (DHS at the time) 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 was created and licensed as a Knox-Keene plan to hold Kaiser's GMC Contracts and DHCS 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 Amador, El Dorado, Placer and Sacramento counties and members who were either previously enrolled or family-linked with Kaiser in the last twelve months. The San Diego GMC service area includes San Diego County and members who were either previously enrolled or family-linked with Kaiser in the last twelve months.

As of July 2016, KFHP's total direct GMC Contract membership was approximately 140,272. Medi-Cal membership, including Seniors and Persons with Disabilities (SPD) and Non-SPD composition:

Line of Business	SPD	Non-SPD	Total
GMC Sacramento	4,821	82,831	**87,652**
GMC San Diego	11,365	41,255	**52,620**
Total GMC Contracts	**16,186**	**124,086**	**140,272**

Local Initiative and COHS Plan Partner Subcontracts

KFHP and 13 other Medi-Cal Managed Care plans (Plan Partners) entered into agreements for KFHP to provide health care services to some Medi-Cal beneficiaries in Two-Plan and County Organized Health System (COHS) model counties in order to expand access and maintain continuity of care. As part of these agreements, Plan Partners fully delegated their Two-Plan and COHS Contract responsibilities for Medi-Cal members assigned to KFHP.

The indirectly contracted population includes Healthy Families Program members originally under KFHP's care. The transition of the Healthy Families Program, during 2013 into the Medi-Cal Program as provided for in AB 1494 (2012, Committee on Budget) resulted in former Healthy Families beneficiaries being assigned to Plan Partners. In order to maintain continuity of care for these members Plan Partners and KFHP entered into Two-Way Care Continuity Agreements and/or subcontracts. In addition, Kaiser, DHCS, and the 13 Plan Partners entered into Three-Way Care Continuity Agreements which include a centralized oversight and compliance process.

As of July 2016, KFHP's total subcontracted Medi-Cal membership is approximately 541,022 composed as follows:

Line of Business	SPD	Non-SPD	Total
Alameda Alliance for Health	1,693	31,211	32,904
CalViva Health	130	7,123	7,253
Contra Costa Health Plan	1,787	29,639	31,426
Health Plan of San Joaquin	142	9,838	9,980
Health Plan of San Mateo	1,168	6,607	7,775
Partnership Health Plan of CA	3,136	60,759	63,895
San Francisco Health Plan	490	8,003	8,493
Santa Clara Family Health Plan	4,949	22,542	27,491
Total NCAL subcontracts	**13,495**	**175,722**	**189,217**
CalOptima	1,988	42,806	44,794
Gold Coast Health Plan	79	4,175	4,254
Inland Empire Health Plan	20,148	81,450	101,598
Kern Family Health Plan	127	6,259	6,386
L.A. Care Health Plan	41,977	152,796	194,773
Total SCAL subcontracts	**64,319**	**287,486**	**351,805**
All subcontracted Health Plans	**77,814**	**463,208**	**541,022**

KFHP and its related entities' total membership (for all lines of business) is approximately 8.1 million (3.9 million members in Northern California and 4.2 million members in Southern California). As of July 2016, KFHP's total Medi-Cal membership (both directly and indirectly contracted) is approximately 681,294 including 94,000 SPD and 587,294 non-SPD.

The scope of this review is the directly contracted GMC and subcontracted 13 Plan Partner non-SPD Medi-Cal population.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of September 1, 2015 through August 31, 2016. The onsite review was conducted from September 26, 2016 through October 7, 2016. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference was held on January 10, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference which is 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 (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of September 1, 2014 through August 31, 2015 with onsite review conducted from September 28, 2015 through October 9, 2015) was issued on January 6, 2016. The corrective action plan (CAP) closeout letter dated September 15, 2016 noted previous findings as closed or provisionally closed. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their CAP. Some, but not all, of the CAP items were operationalized during the audit period.

Eight of the 13 Plan Partners that subcontract with KFHP conducted delegation oversight audits and worked with KFHP to develop CAPs. Three SCAL Plan Partners (CalOptima, Inland Empire Health Plan, and LA Care) conducted annual oversight audits. Five NCAL Plan Partners (Alameda Alliance for Health, Contra Costa Health Plan, Partnership Health Plan of CA, Santa Clara Family Health Plan, and San Francisco Health Plan) conducted joint oversight audits and required corrective action. Five Plan Partners that previously did not have sub-contractual relationships with Kaiser until the Healthy Families Program transition, did not conduct oversight audits (CalViva Health, Gold Coast Health Plan, Health Plan of San Mateo, Health Plan of San Joaquin, and Kern Health Systems).

The results of the Plan Partner oversight activities were considered in developing the audit procedures that were performed under this review. The 2014 and 2015 Plan Partner audit findings and CAPs were reviewed to determine relevancy to this audit. Plan Partner CAPs, to the extent they fell within the scope of this review, were reviewed so that this audit also examined documentation for compliance and to determine to what extent the Plan has operationalized the Plan Partner CAPs. The data samples selected for verification studies include members from the 13 subcontracted Plan Partners. Findings related to the Plan Partner lines of business include the applicable Local Initiative (Two-Plan Model) and COHS Contract citations.

This is a combined report for the Sacramento GMC Contract, San Diego GMC Contract, and 13 Plan Partner subcontracts. Findings and recommendations are reported under **Sacramento GMC, San Diego GMC, NCAL Plan Partner Subcontracts** and/or **SCAL Plan Partner Subcontracts.**

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not ensure that covered orthotic services and supplies were provided in an amount no less than is offered under the Medi-Cal Fee-For-Service Program. Medi-Cal criteria were not used to determine medical necessity for covered orthotic services and supplies for the SCAL Plan Partner subcontracts.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that adult Individual Health Assessments (IHA) included documentation showing the status of evidence-based practice recommendations and that written procedures and provider training directed compliance with the requirement that providers must adhere to the Guide to Clinical Preventive Services for all Medi-Cal lines of business.

Category 3 – Access and Availability of Care

The Plan's access policies and monitoring procedures were not consistent for all Medi-Cal lines of business. The Plan did not monitor the time to obtain prenatal appointments for the NCAL Plan Partner lines of business. The Plan began monitoring this for the Sacramento GMC line of business as part of the DHCS Corrective Action Plan (CAP).

Although the Plan began a documented system and plans for evaluating the monitored Sacramento GMC members' office wait times, NCAL Plan Partner members were not included in this system.

The Plan's maximum appointment/response timeframe to obtain new patient primary care visits in the *2016 NCAL HMO Provider Manual* for contracted or affiliated providers exceeded the Sacramento GMC and NCAL Plan Partner Subcontracts required timeframe.

The Plan's access policy is not consistent with all Medi-Cal lines of business Contracts. Although the Plan monitored GeoAccess for compliance within the Contracts' 10-mile requirement (distance between a member and a primary care physician), the Plan's 15-mile policy was not compliant with the Contracts' requirement.

The Plan did not maintain a complete provider directory in print and online for members in all Medi-Cal lines of business. The Plan's printed provider directory did not include Plan-employed physicians and complete information regarding contracted or affiliated physicians. The Plan's online provider directory did not include contracted or affiliated physicians and did not identify whether a provider is available to Medi-Cal members.

The Plan did not ensure claims were processed within the Contracts timeliness standards. The Plan's claims operating procedures manual listed timeliness standards that differed from the Contracts and monitoring reports were compared to another standard that also differed from the Contracts.

The Plan's claims processing system did not have sufficient controls to ensure that Family Planning claims were paid without requiring prior authorization.

Category 4 – Member Rights

The Plan did not send written notification to members in all Medi-Cal lines of business for grievances that were unresolved within the required contractual time frame. The Plan's grievance notification policy was not implemented.

The Plan did not immediately report Personal Health Information (PHI) breach incidents and provide investigation reports within the required timeframes. The Plan's procedures did not include immediate notification and submission of investigative reports within 72 hours. The Plan did not report breach incident notification and investigative reports to all required DHCS entities. This applied to all Medi-Cal lines of business.

Category 5 – Quality Management

The Plan did not provide training for non-physician providers during the audit period and did not conduct Medi-Cal managed care provider training for newly contracted providers within ten working days after being placed on active status for the Sacramento GMC and NCAL Plan Partner Subcontracts.

The Plan did not provide training for new physicians and non-physician providers during the audit period for San Diego GMC and SCAL Plan Partner Subcontracts.

Category 6 – Administrative and Organizational Capacity

The Plan did not implement procedures to ensure the results of suspected fraud and abuse preliminary investigations were reported to DHCS within ten working days for all Medi-Cal lines of business.

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 26, 2016 through October 7, 2016 at Kaiser Permanente's regional offices 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: 69 medical prior authorization requests (5 from Sacramento GMC, 36 NCAL Plan Partner, 5 San Diego GMC, and 23 SCAL Plan Partner) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 58 appeals of denied grievances and denied prior authorizations (5 from Sacramento GMC, 26 NCAL Plan Partner, 5 San Diego GMC, and 22 SCAL Plan Partner) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Category 2 – Case Management and Coordination of Care

Medical Records: 20 (10 from Sacramento GMC and 10 San Diego GMC) were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Category 3 – Access and Availability of Care

Emergency Service Claims: 27 emergency service claims (2 from Sacramento GMC, 12 NCAL Plan Partner, 3 San Diego GMC, and 10 SCAL Plan Partner) were reviewed for appropriate and timely adjudication.

Family Planning Claims: 28 Family Planning claims (2 from Sacramento GMC, 12 NCAL Plan Partner, 2 San Diego GMC, and 12 SCAL Plan Partner) were reviewed for appropriate and timely adjudication.

Category 4 – Member Rights

Grievance Procedures: 110 grievances (7 from Sacramento GMC, 55 NCAL Plan Partner, 8 San Diego GMC, and 40 SCAL Plan Partner) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 6 Health Insurance Portability and Accountability Act (HIPAA) Personal Health Information (PHI) breach and security incidents (1 from Sacramento GMC, 1 San Diego GMC, and 4 SCAL Plan Partner) were reviewed for processing and reporting requirements.

Category 5 – Quality Management

New Provider Training: 15 new provider training records (1 from Sacramento GMC, 8 NCAL Plan Partner, 1 San Diego GMC, and 5 SCAL Plan Partner) were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: All 20 fraud and abuse cases (2 from Sacramento GMC, 9 NCAL Plan Partner, 2 San Diego GMC, and 7 SCAL Plan Partner) reported during the audit period were reviewed for processing and reporting requirements.

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
GMC Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
GMC Contract A.5.2.G

Timeframes for Medical Authorization:
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1) or any future amendments thereto.
GMC Contract A.5.3.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
GMC Contract A.5.3.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
GMC Contract A.13.8.A

SUMMARY OF FINDINGS:

SCAL Plan Partner Subcontracts

1.2.1 **Prior authorization decisions and utilization criteria**

The Contract requires the Plan to ensure that covered services are provided to a member in an amount no less than what is offered to beneficiaries under the Medi-Cal Fee-For-Service Program. (*Two-Plan and COHS Exhibit A, Attachment 10 (1)(A)*)

The Plan's *UM Program Description from 2015 and 2016 (pages 14 and 16, respectively)* states that the Plan utilizes commercial criteria sets and benefit coverage criteria published by government programs such as Medicare and Medi-Cal to include Medi-Cal coverage guidelines. The Plan's *Policy #: RUM 16, Utilization Management Denial of Practitioner Requested Services (pages 4-5)* states, in part, "UM criteria is used to assist with determinations of medical necessity as part of the UM authorization process" which includes "Medi-Cal Coverage (Per Medi-Cal Provider Manual)."

The Plan did not ensure that covered orthotic services and supplies were provided in an amount no less than is offered under the Medi-Cal Fee-For-Service Program. Medi-Cal criteria were not used to determine medical necessity for covered orthotic services and supplies as evidenced by the verification study:

- Six orthotic cases were denied with the following diagnoses: foot pain, plantar fasciitis, heel pain, bilateral talipes cavus and osteoarthritis. Two of the six cases were requests by podiatrists. According to the Medi-Cal Manual, "prescribed O&P appliances may be covered only as medically necessary to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or alleviate severe pain." The criteria the Plan used did not include pain.

- Compression stockings for venous insufficiency were inappropriately denied in one case. According to the Medi-Cal Manual "custom-made elastic gradient compression stockings are reimbursable with authorization when medically necessary to treat symptomatic venous insufficiency or lymphedema in the lower extremities." The criteria used by the Plan only covered lymphedema and burns.

- In another case the denial was appropriate (based on the peripheral edema diagnosis reported on the Primary Care Physician's request form) but Medi-Cal criteria were not referenced in the denial letter. The denial letter read, "under the terms of your Medi-Cal Health Plan policy, firm fitting compression stockings are covered to treat problems related to: (1) burns (and scars that are a result of the burn); or (2) lymphedema (fluid retention and swelling in the arms and legs from damaged lymph nodes) because the compression garment is expected to help maintain the size of the arm or leg." It did not include venous insufficiency.

The Plan confirmed both orthotics and compression stockings were, and should not have been, denied as Medi-Cal criteria, as indicated in their policy and UM Plan, were not used in these determinations. The Notice of Action (NOA) letters also evidenced a systemic process of not citing Medi-Cal criteria to deny services.

If Medi-Cal criteria are not used in UM decisions, beneficiaries could be denied covered services that are required by the Contracts.

RECOMMENDATION:

SCAL Plan Partner Subcontracts

1.2.1 Develop procedures to ensure Medi-Cal members receive Medi-Cal covered benefits and Medi-Cal criteria are included in the development and implementation of all UM criteria.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	INITIAL HEALTH ASSESSMENT

Initial Health Assessment:

Provision of IHA / IHEBA to Each New Member
Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53851(b), 53902(m), and 53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6. An IHA consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.
GMC Contract Exhibit A.10
COHS Contract Exhibit A.10
Two-Plan Contract Exhibit A.10
MMCD Policy Letter *Initial Comprehensive Health Assessment* 08-003
MMCD Policy Letter *Requirements for SHA/IHEBA* 13-001

Provision of IHAs for Adults, Age 21 and older
Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment. Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes, but is not limited to:
1) A comprehensive history including, but not limited to, mental and physical systems, and social and past medical history.
2) Status of currently recommended preventive services.
3) Comprehensive physical and cognitive exam sufficient to assess and diagnose acute and chronic conditions.
4) Diagnoses and plan of care including follow-up activities.
GMC Contract Exhibit A.10.6.A
COHS Contract Exhibit A.10.6.A
MMCD Policy Letter *Initial Comprehensive Health* Assessment 08-003

Plans must adhere to the current edition of the Guide to Clinical Preventive Services of the US Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Status of current recommended services must be documented.
MMCD Policy Letter *Initial Comprehensive Health Assessment* 08-003

Preventive Services – Adults 21 and Older
Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult
Members. 1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided…As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services.

GMC Contract Exhibit A.10.6 B.
COHS Contract Exhibit A.10.6.B
Two Plan Contract Exhibit A.10.6.B

Follow-up Services
Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA.
GMC Contract Exhibit A.10.8.C
COHS Contract Exhibit A.10.6.A
Two-Plan Contract Exhibit A.10.3.B

Policies and Procedures
Contractor is responsible for submitting policies and procedures for ensuring the provision of the initial health assessment (IHA) and the individual health education behavioral assessment (IHEBA).
GMC Contract Exhibit A.18
COHS Contract Exhibit A.18
Two-Plan Contract Exhibit A.18

Required Written Procedures
All Plans must have written procedures for documentation of IHA, monitoring, scheduling appointments, promotion of IHA completion rate via mechanisms such as quality improvement strategies and training of providers, and informing members about the importance of IHAs, timelines and processes for scheduling and conducting IHAs.
MMCD Policy Letter *Initial Comprehensive Health Assessment* 08-003

SUMMARY OF FINDING:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

2.4.1 **Adult preventive services for Initial Health Assessment**

The Plan must cover and ensure the provision of an Initial Health Assessment (IHA) in conformance with *CCR, Title 22, sections 53851(b), 53902(m), and 53910.5(a)(1)* to each new Member within timelines stipulated in Provision 5 and Provision 6. An IHA consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract. *(GMC, COHS and Two-Plan Exhibit A, Attachment 10; MMCD Policy Letter Initial Comprehensive Health Assessment 08-003, MMCD Policy Letter Requirements for SHA/IHEBA 13-001)*

The IHA for adults must adhere to the current edition of the *Guide to Clinical Preventive Services* of the U.S. Preventive Services Task Force (USPSTF) "A" & "B" recommendations as minimum guidance to determine the provision and frequency of preventive health screening, testing, and counseling. All preventive services identified as USPSTF "A" and "B" recommendations must be provided and the status of current recommended services must be documented. *(GMC, COHS; MMCD Policy Letter 08-003)*

The Plan must have written procedures and must provide training requiring providers to include and document all components of the IHA. *(MMCD PL 08-003)* The Contracts require that the Plan ensure all appropriate staff receive training on a continuing basis regarding evidence-based practice guidelines. *(GMC, COHS and Two-Plan Exhibit A, Attachment 7)*

The Plan did not ensure adult IHAs included documentation showing the status of USPSTF "A" and "B" preventive practice recommendations and that written procedures and provider training directed compliance with this requirement.

The prior DHCS audit included findings that the Plan did not develop and implement written procedures that directed compliance with IHA requirements. As part of the Corrective Action Plan (CAP) the Plan revised its policies but the revision did not include procedures to ensure that USPSTF "A" and "B" guidance for preventive services was used in the performance of IHA.

Plan representatives confirmed that there were no written procedures that directed providers to follow the requirement to provide preventive services according to USPSTF "A" and "B" recommendations. The Plan's policies did not contain procedures to ensure that USPSTF "A" and "B" recommended preventive services were offered and that the status of these services was documented. According to the Plan's medical leadership, providers are not required to use the "A" and "B" recommendations since the USPSTF is but one of many sources in the Plan's electronic clinical library for evidence-based practice; providers are expected to use their clinical judgement with regard to the provision of preventive services. Plan representatives in both Regions confirmed that specific training was not offered to familiarize primary care providers with the requirement to offer evidence-based USPSTF "A" and "B" preventive services in the performance of the IHA.

The Plan's electronic health record system contains prompts to remind providers to conduct preventive health screening for some but not all USPSTF "A" and "B" recommendations. For example, there is a prompt for colorectal cancer screening but not for hepatitis C. The USPSTF recommendation for colorectal screening is to screen all adults between ages 50 and 75. If a patient aged 55 visits her primary care provider, there will be an electronic health record prompt that alerts the provider to the need for review of the patient's colorectal cancer screening status but there is no prompt to remind the provider the patient may be due for the one-time hepatitis C screening recommended by USPSTF for all adults born between 1945 and 1965.

A review of IHAs in 12 member medical records was conducted to determine if providers followed USPSTF "A" and "B" guidance for preventive services and the requirement to document the status of those services. The preventive services or the status of these services for such categories as Hepatitis C, use of aspirin as a preventive measure, depression, and HIV among others were not always documented and providers were not systematically prompted to review these with the members.

Chronic diseases including cancer, type 2 diabetes, obesity, stroke, and heart disease are among the most preventable of health problems *(CDC 2016 [1])*. The guidance to health care providers regarding preventive services is based on research that demonstrated the power to detect or prevent these same chronic diseases *(USPSTF 2016 [2])*. When managed care health plans implement evidence-based preventive services, both lives and health care dollars may be saved *(Maciosek, Coffield, Flottemesch, Edwards, & Solberb, 2010 [3]).*

RECOMMENDATION:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

2.4.1 Develop policies, systems, and training that direct and support compliance with the requirement that the IHA include the provision of USPSTF "A" and "B" recommended preventive health services.

[1] Centers for Disease Control and Prevention. (2016). Chronic Diseases: The Leading Causes of Death and Disability in the United States. Retrieved from http://www.cdc.gov/chronicdisease/overview/

[2] United States Preventive Services Taskforce. (2016). Recommendations. Retrieved from https://www.uspreventiveservicestaskforce.org/

[3] Maciosek, M.V., Coffield, A.B., Flottemesch, T.J., Edwards, N.M., & Solberg, L.I. (2010). Greater use of preventive services in U.S. health care could save lives at little or no cost. *Health Affairs* 29(9):1656-1660. doi:10.1377/hlthaff.2008.0701

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
GMC Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
GMC Contract A.9.4.B.

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
GMC Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
GMC Contract A.9.3.C

SUMMARY OF FINDINGS:

NCAL Plan Partner Subcontracts

3.1.1 **Monitoring prenatal care appointments**

The Two-Plan Contract states the Plan shall ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request; the COHS Contract states within ten business days. (*Two-Plan and COHS Exhibit A, Attachment 9 (3)(B)*)

The Contracts state, in part, that the Plan "shall develop, implement, and maintain a procedure to monitor time to obtain various types of appointments". (*Two-Plan and COHS Exhibit A, Attachment 9 (3)(C)*)

The Plan did not monitor the time to obtain prenatal appointments for NCAL Plan Partner lines of business.

The Plan developed a new policy, *Access to Care - Medi-Cal Prenatal Visit/Encounter Access Standard*, effective August 10, 2016, establishing the first prenatal appointment standard as a corrective action for the prior DHCS audit finding. The Plan developed a prenatal care appointment monitoring mechanism only for GMC members that initially measured the prenatal access time frame data from September 2014 thru August 2015. Plan staff indicated that it would present the prenatal monitoring report to the Sacramento Quality Committee starting with the October 2016 meeting. Both the prenatal appointment standard and its monitoring mechanism are only for the GMC Medi-Cal line of business and did not include members from the NCAL Plan Partner lines of business.

3.1.2 **Documented system for monitoring and evaluating wait times in provider offices**

The Contracts state that the Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices. (*Two-Plan and COHS Exhibit A, Attachment 9 (3)(C)*) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (*CCR, Title 28, 1300.67.2 (f)*)

Although the Plan began a documented system and plans for evaluating the Sacramento GMC members' office wait times, NCAL Plan Partner members were not included in this system.

The Plan's corrective actions from the prior DHCS audit indicated that the GMC Department will produce a provider office wait time report on a quarterly basis and that it will be submitted to the Quality Improvement Committee (QIC) on a bi-annual basis. The initial report submitted during the approval of the corrective action included a data run for the first quarter of 2016 showing an average wait time for office visits in the Sacramento GMC area. Plan staff indicated that these reports were not yet sent to the QIC.

The Plan indicated that there were no plans to include NCAL Plan Partner members in the monitoring process developed for the Sacramento GMC corrective action as wait time issues can be addressed first-hand on a clinical level at provider sites including care from an alternate provider. This clinical level monitoring does not include a documented system for monitoring and evaluating accessibility of care for NCAL Plan Partner members beyond the Sacramento GMC area.

Sacramento GMC and NCAL Plan Partner Subcontracts

3.1.3 **Primary care appointment standard**

The Contracts state members must be offered non-urgent primary care appointments within ten business days of request. (*GMC and Two-Plan Exhibit A, Attachment 9 (4)(B) and COHS Exhibit A, Attachment 9 (3)(A)(2)(c)*)

The Plan's maximum appointment/response timeframe to obtain new patient primary care visits for contracted or affiliated primary care practitioners did not meet the ten business day Contract requirement. The *2016 NCAL HMO Provider Manual* for contracted or affiliated providers indicated maximum primary care practitioner appointment timeframe for new patient visits (without differentiating as either urgent or non-urgent) is 30 business days.

RECOMMENDATIONS:

NCAL Plan Partner Subcontracts

3.1.1 Include Plan Partner members in the prenatal appointment time monitoring process.

3.1.2 Include Plan Partner members in an office wait time monitoring process that is a documented system for monitoring and evaluating accessibility of care.

Sacramento GMC and NCAL Plan Partner Subcontracts

3.1.3 Revise the *2016 NCAL HMO Provider Manual* to clearly reflect the Contracts' primary care appointment requirements.

3.4	SPECIALISTS AND SPECIALTY SERVICES

Specialists and Specialty Services:
Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with W & I Code Section 14182(c)(2).
GMC Contract A.6.6

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.
GMC Contract A.9.3.F

SUMMARY OF FINDINGS:

Sacramento GMC and NCAL Plan Partner Subcontracts

3.4.1 **Primary Care Physician geographic time and distance standard**

The Contracts state that the Plan shall maintain a network of primary care physicians that are located within 30 minutes or 10 miles of a member's residence unless the Plan has a DHCS approved alternative time and distance standard. (*GMC and Two-Plan Exhibit A, Attachment 6 (8)); COHS Exhibit A, Attachment 6 (7)*)

The Plan's policy requirement that a primary care physician be located within 30 minutes or 15 miles of a member's residence does not meet the Contract requirements. The Contract requires that Primary Care Physicians be located within 30 minutes or 10 miles of a member's residence.

The Plan's *Availability Standards for Primary Care, Specialists, Behavioral Health Practitioners and Providers* policy states that the Plan will monitor and ensure that 95% of members will have a residence or work within 30 minutes of 15 miles of primary care, hospital and ancillary services. The Plan's GeoAccess survey results determined the geographic distance from a member's residence to a Primary Care Physician according to the Contract standard of 10 miles or 30 minutes. The Plan acknowledged the policy language discrepancy and stated revisions would be forthcoming.

San Diego GMC and SCAL Plan Partner Subcontracts

3.4.1 **Primary Care Physician geographic time and distance standard**

The Contracts state the Plan shall maintain a network of Primary Care Physicians that are located within 30 minutes or 10 miles of a member's residence unless the Plan has a DHCS approved alternative time and distance standard. (*GMC and Two-Plan Exhibit A, Attachment 6 (8)); COHS Exhibit A, Attachment 6 (7))*

The Plan's policy requirement that a primary care physician be located within 30 minutes or 15 miles of a member's residence do not meet the Contract requirements. The Contract requires that primary care physicians be located within 30 minutes or 10 miles of a member's residence.

The Plan's *Availability Standards Definition of Primary Care Practitioners and Specialists and Procedure for Conducting and Documenting Availability Analysis* policy states that the Plan will monitor and ensure that 95% of members will have a residence or work within 30 minutes of 15 miles of primary care, hospital and ancillary services. The Plan's GeoAccess survey results determined the geographic distance from a member's residence to a primary care physician according to the Contract standard of 10 miles or 30-minutes.

A prior audit by a Plan Partner addressed the issue that the Plan's policies and monitoring standards for distance from a member's residence to a primary care physician did not meet the DHCS requirement of 10 miles or 30 minutes. The Plan staff stated the policy was not revised because it was not part of the Plan Partner's Corrective Action Plan.

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

3.4.2 **Online and printed Provider Directory**

The Contracts state that the Plan shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with *Welfare & Institutions Code, section 14182(c)(2)*. As part of *W&I Code, section 14182(c)(2)*, managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and internet website. (*GMC and Two-Plan Exhibit A, Attachment 6 (6); COHS, Exhibit A, Attachment 6 (5)*)

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(d)*)

A full service health care service plan shall include all of the following information in the provider directory or directories: the provider's name, practice location or locations, and contact information; type of practitioner; National Provider Identifier number; California license number and type of license; area of specialty, including board certification, if any; and identification of providers who no longer accept new patients for some or all of the plan's products. (*H&S Code, section 1367.27(h)*)

The Plan did not maintain a complete provider directory to members in print and online. Instead, members are instructed to contact the Member Services Department to obtain information about primary care, specialty care, ancillary provider and facilities.

The Plan's printed provider directory did not include Plan-employed physicians and complete information regarding contracted or affiliated physicians. The Plan maintains a separate Guidebook for each service area informing members of Plan owned medical centers, medical offices, and specialty facilities, in addition to contracted physicians. Information for contracted providers listed in the Guidebooks did not include the National Provider Identifier number, California license number and type of license, and the ability of the contracted providers to accept new patients.

The Plan's online directory did not include the contracted or affiliated physicians. In addition, the printed Guidebooks, separate for each Plan-owned medical center, medical offices, and specialty facilities, are not available online.

3.4.3 **Provider Directory for Medi-Cal members**

The Contracts state the Plan shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with *W&I Code, section 14182(c)(2)*. As part of *W&I Code, section 14182(c)(2),* managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and internet website. (*GMC and Two-Plan Exhibit A, Attachment 6 (6); COHS Exhibit A, Attachment 6 (5)*)

A health care service plan shall provide the directory or directories for the specific network offered for each product that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify the networks and plan products. (*H&S Code, section 1367.27(b)*)

The Plan's online provider directory did not identify whether a provider was available to Medi-Cal members. The Plan's online provider directory encompasses all Kaiser employed providers for all lines of business. The online provider directory stated, under each individual physician's profile, that providers listed are available to most members. Plan staff indicated, during the onsite interviews, that any member may seek treatment through any Plan physician, regardless of line of business. In contrast, the online provider directory indicated that Medi-Cal members are instructed to call Member Services to ensure a specific provider is accepting Medi-Cal.

RECOMMENDATIONS:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

3.4.1 Revise policies to ensure member access to a primary care physician within the required geographic time and distance standard.

3.4.2 Update provider directories, online and in-print, to ensure they contain a complete list of providers available to members and contain all the necessary provider information.

3.4.3 Update the provider directory to ensure it accurately identifies whether a provider is available to Medi-Cal members.

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with the Contractor.
GMC Contract A.8.13

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge….
GMC Contract A.8.13.B.1

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
GMC Contract A.8.13.B.2

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3
GMC Contract A.8.13.B.3

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1).
GMC Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
GMC Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section…Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.

GMC Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

3.5.1 **Claims processing timeliness**

The Contracts state the Plan shall pay 99 percent of all clean claims within 90 days. (*Two-Plan Exhibit A, Attachment 8 (5)(B); COHS Exhibit A, Attachment 8 (4)(B); and 42 U.S.C., section 1396a(a)(37))*

The Plan did not ensure the payment of 99% of all clean claims within 90 days.

The Plan's *Medi-Cal Reference Guide*, claims operating procedures manual, stated standard was "At least 95% of all claims must be paid or denied within 45 working days". The reference guide lists claims processing standards for each Medi-Cal line of business. The claims processing timeliness standards for all NCAL Plan Partners and two SCAL Plan Partners did not agree with the Contract requirements.

The Plan staff stated that the timeliness guidelines listed are as directed and contracted by each Plan Partner. Review of the Plan Partner policies, provider manuals, and delegation agreements found that the Plan Partner's stated claims timeliness standards meet DHCS Contract requirements but differ from the Plan's listed standards.

The Plan monitored whether 99.75% of claims are paid within 60 days for all Medi-Cal lines of business:

The Sacramento GMC and NCAL Plan Partners claims were monitored by line of business; the Sacramento GMC and eight of nine Plan Partner lines of business were between 92.5% and 98.4% within 60 days. The Plan did not ensure payment of 99% of all clean claims within 90 days.

The San Diego GMC and SCAL Plan Partners claims monitoring was calculated as an average resulting in 99.63% of claims paid within 60 days. However, monitoring claims payments as an average did not ensure that 99% of all clean claims within 90 days were paid for each individually contracted Medi-Cal line of business.

Sacramento GMC and NCAL Plan Partner Subcontracts

3.5.2 **Family Planning claim denials**

Members have the right to access family planning services through any family planning provider without prior authorization. (*GMC and Two-Plan Exhibit A, Attachment 9 (9)(A); COHS Exhibit A, Attachment 9 (8)(A)*)

The Plan did not ensure Family Planning claims were adjudicated without requiring prior authorization. The Plan's current electronic claims processing system automatically denied out of network Family Planning claims. These claims required a manual override by a claims processor.

The Plan denied five claims citing the services were not authorized or prescribed by a Plan physician and are not payable. The Plan stated that the services were denied in error and remediated the claims for release of payment and interest effective October 6, 2016.

The *Medi-Cal Reference Guide* instructs claims processors to pay Family Planning claims without a referral. A manual override is required by a claims processor for Family Planning services as the claims processing system does not distinguish between lines of business; the system automatically identifies and notifies claims processors that Family Planning services require a referral. According to the Plan, dedicated Medi-Cal claims processors provide a reference to other claims processors in regards to Medi-Cal claims and do not adjudicate every Medi-Cal claim directly.

The Plan is currently implementing and testing a new claims processing system. The new system is stated to enlist a greater number of automated processes, including the automatic override of Medi-Cal Family Planning claims for lack of prior authorization; eliminating the need for claims processors to manually override Family Planning claims for lack of prior authorization. All lines of business with the exception of Medi-Cal have been migrated to the new claims processing system. Medi-Cal claims are projected to be migrated to the new claims system by December 1, 2016.

This is a repeat finding.

RECOMMENDATIONS:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

3.5.1 Update procedure guides and monitoring reports to ensure claims processing timeliness standards meet Contract requirements.

Sacramento GMC and NCAL Plan Partner Subcontracts

3.5.2 Implement and ensure the new claims processing system adjudicates Family Planning claims without prior authorization.

CATEGORY 4 – MEMBER RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).
GMC Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
GMC Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
GMC Contract A.14.3.A

SUMMARY OF FINDING:

NCAL and SCAL Plan Partner Subcontracts

4.1.1 **Member grievance notification**

The Contracts state the Plan shall resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan is required to provide the member with written notification of the grievance resolution and its estimated completion date. *(COHS and Two-Plan Exhibit A, Attachment 14 (1) and CCR, Title 22, section 53858 (g)(2))*

Plan *Policy #: 50-2M, Grievance Process for Resolution of Managed Medi-Cal Member Issues* states that if for any reason a resolution cannot be provided within the 30-day time-frame, the member will be notified in writing of the reason for the delay and the expected timeframe for providing a resolution.

The Plan did not have sufficient monitoring and oversight to ensure that written notifications were sent to members for unresolved grievances within 30 days. The Plan's grievance notification policy was not implemented as evidenced by the verification study. A total of 109 grievances files were reviewed; eight of which were not resolved within 30 days. Written notifications were not sent for all eight: six NCAL (sent within 32-159 days) and two SCAL (60 and 110 days).

RECOMMENDATION:

NCAL and SCAL Plan Partner Subcontracts

4.1.1 Develop, implement, and monitor a system with sufficient oversight that will ensure members are notified in writing when resolution cannot be provided within 30 days.

4.3	CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:
Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….
GMC Contract G.III.C.2

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. ***Notice to DHCS.*** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. ***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information …to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

GMC Contract G.III.J

SUMMARY OF FINDINGS:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

4.3.1 **Breach incident reporting timeframes**

The Plan is required to notify DHCS immediately upon the discovery of breach of security of Personal Health Information (PHI) in computerized form. *(GMC Exhibit G (H)(1); COHS and Two-Plan Exhibit G (J)(1)(1))* The Plan is required to immediately investigate breach incidents and provide investigation reports to DHCS within 72 hours of the discovery. (*GMC Exhibit G (H)(2); COHS and Two-Plan Exhibit G (J)(1)(2)*) The Plan did not immediately report breach incidents and provide investigation reports within the required timeframes. The Plan's procedures did not include immediate notification and submission of investigative reports within 72 hours.

The Plan developed a *Reference Grid* and *Incident Response Overview* as a corrective action for the prior DHCS audit finding. The *Reference Grid* identifies the Contracts' requirements but only lists Sacramento and San Diego GMC lines of business. The *Incident Response Overview* lists the daily steps of investigation and reporting to DHCS but did not include the 72-hour reporting requirement.

DHCS was not immediately notified, and investigative reports were not submitted within 72 hours of discovery for all six breach incidents reviewed. Based on the DHCS breach log, these cases were initially reported one to 15 days after discovery, and investigative reports were submitted six to 26 days after discovery. The Plan submitted documentation to verify submission of investigative reports but did not provide documentation to verify initial notification.

This is a repeat finding.

4.3.2 **Breach incident reporting requirements**

The Contract requires breach incident notification and investigation reporting to be provided to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. (*GMC Exhibit G (H)(1) and (2); COHS and Two-Plan Exhibit G (J)(1)*)

The Plan did not report breach incident notification and investigative reports to all required DHCS entities. The Plan developed a *Reference Grid* and *Incident Response Overview* as a corrective action for the prior DHCS audit finding. The *Reference Grid* identifies the Contracts requirements but only lists Sacramento and San Diego GMC lines of business. The *Reference Grid* indicates breach incident notification and investigation reporting to be provided to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

The Plan did not have a system in place to maintain the necessary documentation to support whether all six cases were reported to all three DHCS entities. Four out of six cases had no documentation showing that all three DHCS entities were initially notified. In the two cases that had documentation in the DHCS breach log and related notification documentation: one was reported to the DHCS Privacy Officer, but there was no record of reporting to the DHCS Information Security Office and Contract Manager; the other case was reported to the DHCS Privacy Officer and Contract Manager, but not the DHCS Information Security Office.

This is a repeat finding.

RECOMMENDATIONS:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

4.3.1 Develop and implement procedures to ensure and document breach incident notification, investigation and reporting within required timeframes.

4.3.2 Develop and implement procedures to ensure and document breach incident notification and reporting to all required DHCS entities.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
GMC Contract A.4.12

Provider Qualifications:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
GMC Contract A.4.12.A

Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within 10 working days after the Contractor places a newly contracted provider on active status…Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.
GMC Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
GMC Contract A.4.12.B

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
GMC Contract A.4.12.D

SUMMARY OF FINDINGS:

Sacramento GMC and NCAL Plan Partner Subcontracts

5.2.1 **Training for newly contracted providers**

The Contracts require the Plan to conduct training for all providers within ten working days after the Plan places a newly contracted provider on active status. *(GMC and COHS Exhibit A, Attachment 7 (5); Two-Plan 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. *(GMC Exhibit E, Attachment 1, Definitions)*
The Plan did not provide training for non-physician providers during the audit period. The prior DHCS audit included findings that training was not conducted for all providers. As part of the corrective action plan, the Plan implemented a Medi-Cal managed care provider training process in June 2016 for all newly hired physicians to receive the provider training within ten days of hire. The Plan conducted provider training for new physicians but not for non-physicians. According to the Plan, provider training for newly hired non-physician providers will be implemented by the first quarter of 2017.

This is a repeat finding.

San Diego GMC and SCAL Plan Partner Subcontracts

5.2.1 **Training for newly contracted providers**

The Contracts require the Plan to conduct training for all providers within ten working days after the Plan places a newly contracted provider on active status. *(GMC and COHS Exhibit A, Attachment 7 (5); Two-Plan 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. *(GMC Exhibit E, Attachment 1, Definitions)*

The Plan did not implement Medi-Cal managed care training for the following new providers during the audit period:

- New physicians (SCAL Plan Partners)
- New non-physicians (San Diego GMC and SCAL Plan Partners)

The verification study found five of six new SCAL Plan Partner physicians did not receive provider training. The Plan confirmed that there was no Medi-Cal managed care provider training process for new SCAL Plan Partner physicians during the audit period.

The Prior DHCS audit findings included that the Plan did not conduct Medi-Cal managed care provider for all new San Diego GMC providers. As a corrective action for the prior DHCS audit, the Plan developed a new Medi-Cal managed care provider training process for all newly hired physicians and non-physicians scheduled to be implemented in November 2016.

This is a repeat finding.

Sacramento GMC and NCAL Plan Partner Subcontracts

5.2.2 **Newly contracted provider training timeframe**

The Contracts require the Plan to conduct training for all providers within ten working days after the Plan places a newly contracted provider on active status. *(GMC and COHS Exhibit A, Attachment 7 (5); Two-Plan Exhibit A, Attachment 7 (5)(A)*)

The Plan did not conduct Medi-Cal managed care provider training for newly contracted providers within ten working days after being placed on active status. The results of the verification study found two out of nine new physicians did not receive provider training within the required timeframe. The two new physicians completed the training in 84 and 99 days. According to the Plan, the human resource department was responsible for administering provider training and maintaining training attestation records. The Plan however did not have policies or procedures to track provider training completion timeliness.

RECOMMENDATIONS:

Sacramento GMC, San Diego GMC, and NCAL and SCAL Plan Partner Subcontracts

5.2.1 Implement procedures to ensure all new providers receive training as required by the Contracts.

Sacramento GMC and NCAL Plan Partner Subcontracts

5.2.2 Implement policies and procedures to provide training to newly contracted providers within the required timeframe and develop a monitoring system to ensure timely completion.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

GMC Contract E.2.25.B

SUMMARY OF FINDING:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

6.3.1 **Suspected fraud and abuse case reporting**

The Contracts state that 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 is aware of such activity. *(GMC Exhibit E, Attachment 2 (B)(1); COHS and Two- Plan Exhibit E, Attachment 2 (B)(4))*

As a corrective action for the prior DHCS audit finding, the Plan sent an email to the fraud and abuse investigation staff in November 2015 instructing them to meet the ten-day reporting requirement, as well as the requirement to submit a Form 609 to DHCS within ten days of completion of the investigation. The prior DHCS audit included findings that suspected fraud and abuse cases were reported after the completion of the full investigation.

The Plan did not complete and report the results of preliminary investigations to DHCS within ten working days. A total of twenty suspected fraud and abuse incidents were reported to DHCS during the audit period. All twenty included preliminary and final investigation and reporting. Eight (three NCAL, five SCAL) preliminary investigations were not conducted and reported to DHCS within ten working days. Reporting of these cases ranged from 48-86 days (Sacramento GMC and NCAL Plan Partners) and 14-33 days (San Diego GMC and SCAL Plan Partners).

This is an ongoing finding.

RECOMMENDATION:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

6.3.1 Develop and implement procedures that will ensure preliminary investigations for suspected fraud and abuse cases are completed and reported to DHCS within the required timeframe.

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

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

Contract Numbers: 07-65850 Sacramento
09-86160 San Diego
State Supported Services

AND

Kaiser Foundation Health Plan Inc.
LI and COHS Subcontracts

Plan Partners: Alameda Alliance for Health
CalViva Health
Contra Costa Health Plan
Health Plan of San Joaquin
Health Plan of San Mateo
Partnership Health Plan of California
San Francisco Health Plan
Santa Clara Family Health Plan
CalOptima
Gold Coast Health Plan
Inland Empire Health Plan
Kern Family Health Plan
L.A. Care Health Plan

Audit Period: September 1, 2015
Through
August 31, 2016

Report Issued: March 2, 2017

TABLE OF CONTENTS

INTRODUCTION

This report presents the audit findings of KP Cal, LLC State Supported Services Contract No. 07-65850 for Sacramento GMC, Contract No. 09-86160 for San Diego GMC, and 13 Medi-Cal Managed Care Plans (Plan Partners) that subcontract with Kaiser Foundation Health Plan, Inc. (KFHP) under the Local Initiative (LI) and County Organized Health System (COHS) Counties. The State Supported Services Contracts cover contracted abortion services.

The onsite review was conducted from September 26, 2016 through October 7, 2016. The audit period is September 1, 2015 through August 31, 2016 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on January 10, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. No additional information was submitted following the Exit Conference.

Twenty-four state supported services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: KP Cal, LLC. (Sacramento and San Diego GMC) and KFHP, Inc. (LI and COHS Subcontracts)	
AUDIT PERIOD: September 1, 2015 to August 31, 2016	DATE OF AUDIT: September 26, 2016 to October 7, 2016

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 FINDINGS:

Sacramento GMC and NCAL Plan Partner Subcontracts

SSS.1 **State Supported Service claim denials**

The Plan agrees to provide, or arrange to provide, to eligible members, state supported service procedure codes: 59840 through 59857, X1516, X1518, X7724, X7726, and Z0336. *All Plan Letter 15-020* reiterates the Plan's responsibility to provide timely access to abortion services, and must not require prior authorization for outpatient abortion services (*Hyde Contract, Exhibit A (1)*).

The Plan did not ensure that State Supported Service claims were adjudicated without requiring prior authorization. The Plan's current electronic claims processing system automatically denied State Supported Service claims. These claims required a manual override by a claims processor.

The Plan denied one claim citing the services were not authorized or prescribed by a Plan physician and are not payable. The Plan stated that one service was denied in error and remediated the claim for release of payment and interest effective October 6, 2016. Another claim was denied due misinterpretation of Contract language by a claims processor and is being reprocessed for payment as of October 12, 2016.

The *Medi-Cal Reference Guide*, claims operating procedures manual, instructs claims processors to pay State Supported Service claims without a referral. A manual override is required by a claims processor for State Supported Services as the claims processing system does not distinguish between lines of business; the system automatically identifies and notifies claims processors that State Supported Services require a referral. According to the Plan, dedicated Medi-Cal claims processors provide a reference to other claims processors in regards to Medi-Cal claims and do not adjudicate every Medi-Cal claim directly.

The Plan is currently implementing and testing a new claims processing system. The new system is stated to enlist a greater number of automated processes, including the automatic override of Medi-Cal State Supported Service claims for lack of prior authorization; eliminating the need for claims processors to manually override State Supported Service claims for lack of prior authorization. All lines of business with the exception of Medi-Cal have been migrated to the new claims processing system. Medi-Cal claims are projected to be migrated to the new claims system by December 1, 2016.

San Diego GMC and SCAL Plan Partner Subcontracts

SSS.1 **State Supported Service claim denials**

The Plan agrees to provide, or arrange to provide, to eligible members, State Supported Service procedure codes: 59840 through 59857, X1516, X1518, X7724, X7726, and Z0336. *All Plan Letter 15-020* reiterates the Plan's responsibility to provide timely access to abortion services, and must not require prior authorization for outpatient abortion services (*Hyde Contract, Exhibit A (1)*).

The Plan did not ensure that State Supported Service claims were adjudicated without requiring prior authorization. The Plan denied two claims citing the services were not authorized or prescribed by a Plan physician and are not payable. The Plan stated that the services were denied in error and remediated the claims for release of payment and interest effective September 28, 2016.

The *Medi-Cal Reference Guide*, claims operating procedures manual, instructs claims processors to pay State Supported Service claims without a referral. A manual override is required by a claims processor for State Supported Services as the claims processing system does not distinguish between lines of business; the system automatically identifies and notifies claims processors that State Supported Services require a referral. According to the Plan, dedicated Medi-Cal claims processors provide a reference to other claims processors in regards to Medi-Cal claims and do not adjudicate every Medi-Cal claim directly.

The Plan is currently implementing and testing a new claims processing system. The new system is stated to enlist a greater number of automated processes, including the automatic override of Medi-Cal State Supported Service claims for lack of prior authorization; eliminating the need for claims processors to manually override State Supported Service claims for lack of prior authorization. All lines of business with the exception of Medi-Cal have been migrated to the new claims processing system. Medi-Cal claims are projected to be migrated to the new claims system by December 1, 2016.

RECOMMENDATION:

Sacramento GMC, San Diego GMC, NCAL and SCAL Plan Partner Subcontracts

SSS.1 Implement and ensure the new claims processing system adjudicates State Supported Service claims without prior authorization.