

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

KP Cal, LLC
Kaiser Permanente GMC

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

Audit Period: September 1, 2014
Through
August 31, 2015

Report Issued: January 6, 2016

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management.....	7
	Category 2 – Case Management and Coordination of Care	9
	Category 3 – Access and Availability of Care	11
	Category 4 – Member Rights	15
	Category 5 – Quality Management	18
	Category 6 – Administrative and Organizational Capacity	20

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 (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 and Southern California 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.

KFHP and its related entities' total membership (for all lines of business) is approximately 7.9 million (3.9 million in Northern California and 4 million in Southern California). As of July 1, 2015, KFHP's total Medi-Cal membership is approximately 602,057. Medi-Cal membership composition:

- 476,970 subcontracted from 13 other Medi-Cal contracted health plans
- 125,087 directly contracted with DHCS under GMC contracts:
 - 76,820 Sacramento GMC
 - 4,780 Seniors and Persons with Disabilities (SPD's)
 - 72,040 non-SPD's
 - 48,267 San Diego GMC
 - 10,624 SPD's
 - 37,643 non-SPD's

The scope of this review is the directly contracted GMC, 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, 2014 through August 31, 2015. The on-site review was conducted from September 28, 2015 through October 9, 2015. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference was held on December 2, 2015 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.

This is a combined report for both the Sacramento GMC and San Diego GMC contracts. Common findings and recommendations are reported under **Sacramento and San Diego GMC** and 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 GMC

The Plan's prior authorization decisions for Durable Medical Equipment (DME) requests were not consistent with its utilization criteria.

Category 2 – Case Management and Coordination of Care

Sacramento and San Diego GMC

The Plan did not develop and implement initial health assessment (IHA) policies and procedures to guide compliance with requirements to monitor IHA completion, train providers, inform members, and promote IHA completion through quality improvement strategies.

Category 3 – Access and Availability of Care

Sacramento GMC

The Plan did not establish the first prenatal visit access standard. The Plan did not monitor the completion rate for the first prenatal visit. The Plan's policy describes oversight and monitoring of access standards but did not include monitoring of the first prenatal visit.

The Plan's claims processing timeliness standards differed from, and do not ensure compliance with those of the Contract. The Plan incorrectly denied some out-of-network family planning claims.

San Diego GMC

The Plan did not set the access standard for the first prenatal visit. The Plan's Policy describes oversight and monitoring of access standards but did not include the standard for the first prenatal visit.

Sacramento and San Diego GMC

The Plan did not monitor wait times in the providers' offices.

Category 4 – Member Rights

Sacramento GMC

The Plan's subcontractor business associate agreement breach reporting timeframe requirements exceed those of the Contract which precluded the Plan from meeting the Contract requirements.

Sacramento and San Diego GMC

The Plan did not report breaches of Personal Health Information (PHI) to the DHCS within required timeframes.

The Plan did not report breach of PHI incidents and investigations to all required DHCS entities.

Category 5 – Quality Management

Sacramento and San Diego GMC

The Plan did not conduct Medi-Cal managed care training for all new providers.

Category 6 – Administrative and Organizational Capacity

Sacramento and San Diego GMC

The Plan did not report suspected fraud and abuse cases to the DHCS within the required time frame.

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 contract.

PROCEDURE

The on-site review was conducted from September 28, 2015 through October 9, 2015 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: 67 medical prior authorization requests (29 Sacramento GMC and 38 San Diego GMC) were reviewed for timeliness, consistent application of criteria, and appropriate review. No medications require prior authorization under Kaiser's Utilization Management Program.

Appeal Procedures: 27 appeals of denied grievances and denied prior authorizations (14 Sacramento GMC and 13 San Diego GMC) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Category 2 – Case Management and Coordination of Care

Fifty-six medical records (28 Sacramento GMC and 28 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: 24 emergency service claims (12 Sacramento GMC and 12 San Diego GMC) were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims (10 Sacramento GMC and 10 San Diego GMC) were reviewed for appropriate and timely adjudication.

Category 4 – Member Rights

Grievance Procedures: 73 grievances (37 Sacramento GMC and 36 San Diego GMC) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 2 Health Insurance Portability and Accountability Act (HIPAA) Personal Health Information (PHI) Breach and Security incidents (1 Sacramento GMC and 1 San Diego GMC) were reported during the audit period and reviewed for processing and reporting requirements.

Category 5 – Quality Management

New Provider Training: 20 new provider training records (10 Sacramento GMC and 10 San Diego GMC) were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 12 fraud and abuse cases (8 Sacramento GMC and 4 San Diego GMC) were reported during the audit period and reviewed for processing and 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, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

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 FINDING:

Sacramento GMC

1.2.1 Prior Authorization Decisions and Utilization Criteria

The Plan must use evaluation criteria and standards to approve, modify, defer or deny services (*Contract, Exhibit A, Attachment 5(1)(D)*). In addition, the Plan must ensure that written guidelines for utilization review are consistently applied (*Contract, Exhibit A, Attachment 5(2)(B)*).

The Plan's 2015 UM Program states, "The determination of whether a service is medically necessary is based on medical necessity UM criteria and the review of clinical information from various sources... including ...treating practitioners, (and) specialists."

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan's criteria for compression stockings stated that these DME items are a covered benefit when prescribed for venous insufficiency requiring a minimum of 21 mmHg of pressure.

The Plan's prior authorization decisions for compression stockings (a DME item) requests were not consistent with its utilization criteria. Six denials for compression hose were reviewed. In all cases, the physician determinations did not expand upon the initial review by RN evaluators who noted that there was no evidence of venous insufficiency. A review of the medical records found the following:

- Case 30: A vascular surgeon documented a member's pedal edema and severe venous reflux consistent with venous insufficiency and dysfunction. The Plan subsequently denied the specialist's request for compression hose of 20-30 mmHg in spite of the case meeting UM criteria. There was no documented communication from the physician UM decision-maker to the requesting surgeon for more information before the denial in spite of the diagnosis of a problem requiring medical treatment and surgery.
- Case 41: A provider diagnosed stasis dermatitis indicative of venous insufficiency for a diabetic member with symptomatic varices. The prescription for level one compression hose was denied first by the RN evaluator and then the MD reviewer. There was no documented communication from the physician UM decision-maker to the requesting provider for additional pertinent information.
- Case a4: A vascular surgeon diagnosed venous hypertension and documented varicose veins with severe reflux before recommending compression hose and vein surgery for the member. There was no documented communication from the physician UM decision-maker to the requesting provider for a further description of his concerns and the request for compression hose was denied, first by the RN evaluator and then by the MD reviewer.

RECOMMENDATION:

Sacramento GMC

- 1.2.1 Ensure consistent application of UM criteria.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

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 A.18.10A

Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR 53851(b), 53902(m), & 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 A.10.3.A

MMCD PL Initial Comprehensive Health Assessment 08-003.

MMCD Policy Letter PL Requirements for SHA/IHEBA 13-001

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 A.10.8.C

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less. For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment. Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each Member under 21 years of age at the time of enrollment is accomplished at the IHA. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the Member under 21 years of age is up-to-date.

GMC Contract A.10.5.A

MMCD PL Initial Comprehensive Health Assessment 08-003.

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.

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members.

GMC Contract A.10.6.A

MMCD PL Initial Comprehensive Health Assessment 08-003.

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 PL Initial Comprehensive Health Assessment 08-003.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

SUMMARY OF FINDINGS:

Sacramento GMC

2.4.1 Provision of Initial Health Assessments

The Plan must develop a policy with procedures to ensure provision of the IHA (*Contract Exhibit A, Attachment 18*). The Plan must establish written procedures for monitoring IHA completion, training providers, informing members, and promoting IHA completion rates through mechanisms such as quality improvement strategies (*MMCD Policy Letter 08-003, Initial Comprehensive Health Assessment*).

The Plan did not develop and implement policies and procedures that meet contract requirements for the provision of IHAs, monitoring IHA completion, training providers, informing members, and promoting the IHA completion rate through mechanisms such as quality improvement strategies. The Plan did not have a policy that directed compliance with IHA requirements. The Plan's procedures monitored the occurrence of visits but its methodology did not confirm that the medical record contained the required elements of an initial comprehensive health assessment as defined by the California Code of Regulations, Title 22, Sections 53851(b)(1), 53902(m), and 53910.5(a)(1); *Contract, Exhibit A Attachment 10(3)(A)*; and *MMCD Policy Letter 08-003 Initial Comprehensive Health Assessment*.

San Diego GMC

2.4.1 Provision of Initial Health Assessments

The Plan must develop a policy with procedures to ensure provision of the IHA (*Contract Exhibit A, Attachment 18*). The Plan must establish written procedures for monitoring IHA completion, training providers, informing members, and promoting IHA completion rates through mechanisms such as quality improvement strategies (*MMCD Policy Letter 08-003, Initial Comprehensive Health Assessment*).

The Plan did not develop and implement policies and procedures that meet contract requirements for the provision of IHAs, monitoring IHA completion, training providers, informing members, and promoting the IHA completion rate through mechanisms such as quality improvement strategies. The Plan did not have a policy that directed compliance with IHA requirements. According to narrative documents and interviews with Plan staff, a process for monitoring IHA visit compliance had not been established during the audit period. A policy with procedures for IHA requirements was under construction at the time of the audit. Monitoring of IHA completion was not conducted during the audit period.

RECOMMENDATION:

Sacramento and San Diego GMC

- 2.4.1 Develop and implement a policy for provision of the IHA with written procedures that guide compliance with requirements to monitor IHA completion, train providers, inform members, and promote IHA completion through quality improvement strategies.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

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:

Sacramento GMC

3.1.1 First Prenatal Visit Access Standard and Monitoring

The Plan is required to implement and maintain procedures to ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request (*Contract, Exhibit A, Attachment 9 (3)(A)(B)*).

The Plan did not establish the first prenatal visit access standard. The Plan did not monitor the completion rate for the first prenatal visit. The Plan's policy, *Access to Care – Time Elapsed Standards*, describes access standards for various appointment types but did not include the standard for the first prenatal visit. The Plan's policy, *Oversight & Monitoring for Access and Availability*, describes oversight and monitoring of access standards but did not include monitoring of the first prenatal visit.

San Diego GMC

3.1.1 First Prenatal Visit Access Standard

The Plan is required to implement and maintain procedures to ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request (*Contract, Exhibit A, Attachment 9 (3)(A)(B)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan did not establish the access standard for the first prenatal visit. The Plan's Policy, *Oversight & Monitoring for Access and Availability*, describes oversight and monitoring of access standards but not the standard for the first prenatal visit. Although not included in the policy, the Plan did monitor the two week completion rate.

Sacramento and San Diego GMC

3.1.2 Monitoring Waiting Times in Providers' Offices

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the providers' offices (*Exhibit A, Attachment 9 (3)(C)*).

The Plan did not develop, implement, and maintain a formal process to monitor wait times in the providers' offices.

RECOMMENDATIONS:

Sacramento GMC

3.1.1 Establish access standard and monitor members' access for the first prenatal visit.

San Diego GMC

3.1.1 Establish access standard for the first prenatal visit.

Sacramento and San Diego GMC

3.1.2 Develop, implement, and maintain a procedure to monitor wait times in the providers' offices.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

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

3.5.1 Timely Claims Processing

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan is required to pay 99% of all clean claims within 90 days (*Contract, Exhibit A, Attachment 8 (5)(A)(B), and 42 U.S. Code §1396a(a)(37)*).

The Plan's claims processing timeliness standards differed from, and do not ensure compliance with those of the Contract. The Plan's Medi-Cal Reference Guide for Northern California Claims Processing states "at least 95% of ALL claims must be paid or denied within 45 working days."

3.5.2 Out-of-Network Family Planning Claims

Members have the right to access family planning services through any family planning provider without prior authorization (*Contract, Exhibit A, Attachment 9 (8)(A)*). Members may also access family planning services from out-of-network providers (*Exhibit A, Attachment 9 (8)(A)(2)*).

The Plan incorrectly denied some out-of-network family planning claims. The Plan denied four claims citing the services were not prescribed or authorized by a Plan physician and therefore not payable. The claims were routed to the commercial instead of the Medi-Cal queue and denied in error.

RECOMMENDATIONS:

Sacramento GMC

- 3.5.1 Ensure claim processing timeliness standards are met.
- 3.5.2 Ensure out-of-network family planning claims are paid.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

CATEGORY 4 – MEMBER RIGHTS

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

4.3.1 Breach Incident Reporting Timeframes

The Plan is required to notify DHCS immediately upon the discovery of breach of security of PHI in computerized form (*Contract, Exhibit H (1)*). The Plan is required to immediately investigate breach incidents and provide investigation reports to DHCS within 72 hours of the discovery (*Contract, Exhibit G H (2)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan did not report a breach incident to the DHCS within either of these required timeframes. The Plan reported one breach incident during the audit period 17 days after discovery.

4.3.2 Breach Incident Investigation and Reporting

The Contract requires breach incident notification and investigation reporting to be provided to the DHCS Contracting Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer (*Contract, Exhibit G (H) (1) and (2)*).

The Plan did not report a breach incident and investigation to all required DHCS entities. The Plan did not provide notification of a breach incident to the DHCS Contracting Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. The Plan submitted the investigation report to the DHCS Privacy Officer and the DHCS Information Security Office, but not the DHCS Contracting Manager.

4.3.3 Subcontractor Breach Reporting Requirements

The Plan is required to notify DHCS immediately upon the discovery of breach of security of PHI in computerized form (*Contract, Exhibit H (1)*). The Plan is required to ensure that any agents, including subcontractors, agree to the same restrictions and conditions that apply to the Plan with respect to PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each subcontract. (*Contract, Exhibit G (D)*).

Delegation of any obligation or requirement to a subcontractor by a plan shall not release the plan from the responsibility to discharge any obligation or comply with any requirement contained in the contract between the Plan and the Department (California Code of Regulations, Title 22, Section 53867).

The Plan's subcontractor business associate agreement breach reporting timeframe requirements exceed those of the Contract that precluded the Plan from meeting the Contract requirements. The Plan's subcontractor reported a breach incident to the Plan five days after the incident occurred, then the Plan reported it to DHCS 17 days after discovery (see Finding 4.3.1). The subcontract business associate agreement addendum (a standard addendum for all of the Plan's subcontracts involving PHI and was amended April 2, 2014) follows US Department of Health & Human Services breach notification rules to provide notice to the Plan no later than 60 days from the discovery of the breach.

San Diego GMC

4.3.1 Breach Incident Reporting Timeframes

The Plan is required to notify DHCS immediately upon the discovery of breach of security of PHI in computerized form (*Contract, Exhibit H (1)*). The Plan is required to immediately investigate breach incidents and provide investigation reports to DHCS within 72 hours of the discovery (*Contract, Exhibit G (H) (2)*).

The Plan did not report a breach incident to the DHCS within either of these required timeframes. The Plan reported one breach incident during the audit period 206 days after discovery.

4.3.2 Breach Incident Investigation and Reporting

The Contract requires breach incident notification and investigation reporting to be provided to the DHCS Contracting Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer (*Contract, Exhibit G (H) (1) and (2)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan did not report a breach incident and investigation to all required DHCS entities. The Plan reported a breach to the DHCS Privacy Officer, but has no record of reporting to the DHCS Information Security Office and Contracting Manager.

RECOMMENDATIONS:

Sacramento and San Diego GMC

- 4.3.1 Ensure compliance with breach notification timeliness reporting requirements.
- 4.3.2 Ensure compliance with breach notification entity reporting requirements.

Sacramento GMC

- 4.3.3 Ensure subcontractor business associate agreements are consistent with contract requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

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

5.2.1 New Provider Medi-Cal Managed Care Training

The Plan is required to “conduct training for all providers within 10 working days after the Plan places a newly contracted provider on active status.” (*Contract, Exhibit A, Attachment 7, 5*) 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*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

The Plan did not conduct Medi-Cal managed care provider training for all new providers. The new provider list showed that only primary care physicians received Medi-Cal Managed Care training. Interview with the Plan confirmed only primary care physicians received this training.

San Diego GMC

5.2.1 New Provider Medi-Cal Managed Care Training

The Plan is required to “conduct training for all providers within 10 working days after the Plan places a newly contracted provider on active status.” (*Contract, Exhibit A, Attachment 7, 5*) 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*)

The Plan did not conduct Medi-Cal managed care training for all new providers. Plan staff confirmed that Medi-Cal managed care training was only for primary care physicians and that nurse practitioners did not receive this training. Documentation provided by the Plan verified that per diem providers, nurse practitioners, and contracted providers were not included in Medi-Cal managed care training.

RECOMMENDATION:

Sacramento and San Diego GMC

5.2.1 Ensure all new providers receive provider training as required by the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

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.
- 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-

GMC Contract E.2.25.B

SUMMARY OF FINDINGS:

Sacramento GMC

6.3.1 Suspected Fraud and Abuse Case Reporting.

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 is aware of such activity (*Contract, Exhibit E, Attachment 2 (B)(1)*).

The Plan did not report suspected fraud and abuse cases to the DHCS within the required time frame. The Plan notified DHCS of eight suspected fraud and abuse incidents related to beneficiary pain medication use during the audit period. The Plan did not complete preliminary investigations and report the results to the DHCS within ten working days for all eight incidents. The Plan reported these cases upon completion of the full investigation which was between 21 and 119 days after the discovery date.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

DATE OF AUDIT: September 28, 2015 through October 9, 2015

San Diego GMC

6.3.1 Suspected Fraud and Abuse Case Reporting.

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 is aware of such activity (*Contract, Exhibit E, Attachment 2 (B)(1)*).

The Plan did not report suspected fraud and abuse cases to the DHCS within the required time frame. The Plan notified DHCS of four suspected fraud and abuse incidents related to beneficiary pain medication use during the audit period. The Plan did not complete preliminary investigations and report the results to the DHCS within ten working days for three of these incidents. The Plan reported these three cases upon completion of the full investigation which was between 29 and 139 days after the discovery date.

RECOMMENDATION:

Sacramento and San Diego GMC

- 6.3.1 Ensure all incidents of suspected fraud and abuse are reported to DHCS within ten working days of the date the Plan is aware of such activity.

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

KP Cal, LLC
Kaiser Permanente GMC

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

Audit Period: September 1, 2014
Through
August 31, 2015

Report Issued: January 6, 2016

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

This report presents the audit findings of KP Cal, LLC State Supported Services contract Nos. 07-65850 and 09-86160 for Sacramento and San Diego GMC's. The State Supported Services contracts cover contracted abortion services with KP Cal, LLC.

The on-site review was conducted from September 28, 2015 through October 9, 2015. The audit period is September 1, 2014 through August 31, 2015 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on December 2, 2015 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.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2014 through August 31, 2015

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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:

Sacramento & San Diego GMC

SSS.1 State Supported Services

Policy Letter 98-11 states “parental consent is not required for members under the age of 18 to access pregnancy-related services, including family planning. Parental consent is not required of minors 12 years or older to obtain medical care related to the diagnosis and treatment of sexually transmitted diseases.” In addition, the Office of the Attorney General states minors do not need the consent of their parents to have an abortion in California (*Women's Rights Handbook*).

The Member Handbook states members age 12 or older do not need parental consent for sensitive services including sexually transmitted diseases and abortion services. This is incorrect; although minors 12 years or older do not require parental consent for sexually transmitted disease treatment, minors of any age do not need parental consent for pregnancy related services (*Policy Letter 98-11*).

RECOMMENDATION:

Sacramento & San Diego GMC

SSS.1 Ensure Member Handbook states minors do not need parental consent to obtain abortion services.