

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN FRANCISCO SECTION

**REPORT ON THE MEDICAL AUDIT OF KAISER
FOUNDATION HEALTH PLAN, INC.
2025**

Contract Numbers:

23-30227 – Single Plan

23-30228 – Geographic Managed Care

23-30229 – Two-Plan

23-30230 – Regional

23-30231 – County Organized Health System

Audit Period: November 1, 2024 — December 31, 2025

Dates of Audit: November 3, 2025 — November 14, 2025

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TABLE OF CONTENTS

- I. INTRODUCTION 3
- II. EXECUTIVE SUMMARY 4
- III. SCOPE/AUDIT PROCEDURES 7
- IV. COMPLIANCE AUDIT FINDINGS
 - Category 1 – Utilization Management Program10
 - Category 4 – Grievances, Appeals, and Member Rights21

I. INTRODUCTION

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

In 2005, KP Cal, LLC., was created by the Plan to hold the GMC Contracts. DHCS transferred the GMC Contracts to KP Cal, LLC. KP Cal, LLC. and the Plan entered into a management and administrative services agreement, which delegated administrative and operational functions, such as quality improvement, grievances, and appeals to the Plan. These two entities also entered into a health services agreement to provide health care services to KP Cal, LLC. members through the Plan's network of providers and medical centers. The Plan offers a comprehensive health care delivery system, including physicians, medical centers, hospitals, laboratories, and pharmacies.

As of January 1, 2024, the Plan contracts directly with the DHCS under a new direct contract to provide Medi-Cal services to members in all the geographic regions where the Plan has a commercial footprint. This area comprises 32 counties in the State of California.

The Plan divides its operations into two regions: Northern California (NCAL) and Southern California (SCAL). As of December 31, 2025, the Plan served approximately 1,240,230 (535,688 NCAL and 704,542 SCAL) Medi-Cal members in the following counties:

NCAL: Alameda (76,548), Contra Costa (61,311), Marin (7,138), Napa (8,036), Solano (38,702), Sonoma (25,268), Yolo (6,307), Sacramento (136,037), Amador (380), Placer (18,522), El Dorado (4,009), San Francisco (23,272), San Mateo (18,520), Santa Clara (50,773), Fresno (11,109), Kings (259), Madera (1,864), San Joaquin (32,372), Stanislaus (12,353), Santa Cruz (1,605), Tulare (126), Mariposa (13), Sutter (52), and Yuba (1,112).

SCAL: Orange (72,255), San Diego (72,257), Riverside (93,285), San Bernardino (98,570), Los Angeles (334,639), Kern (23,468), Ventura (10,027), Imperial (35), and Tulare (6).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of November 1, 2024, through December 31, 2025. The audit was conducted from November 3, 2025, through November 14, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 26, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 13, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM) Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights; Quality Improvement and Health Equity Transformation Program; and Plan Administration and Organization.

The prior DHCS medical audit for the period of November 1, 2023, through October 31, 2024, was issued on April 24, 2025. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation and effectiveness of the Plan's prior year 2024 Corrective Action Plan.

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

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan's failure to render a decision and send a written Notice of Action (NOA) letter to the member within the required timeframe is considered a denial of the requested service and therefore constitutes an Adverse Benefit Determination (ABD) on the date that the timeframe expires. For standard authorization decisions, the Plan must provide notice within the state-established timeframe, which must not exceed 14-calendar-days after receiving the service request. Finding 1.2.1: The Plan did not provide members with a NOA for adverse benefit determinations when it did not render authorization decisions for standard service requests within the required timeframe of 14-calendar-days.

The Plan must be able to provide full and immediate translation of written materials for limited English proficiency members who speak threshold or concentration languages and fully translated member information, including member rights information, form letters, and NOAs. NOAs must include a fully translated written notice with clinical rationale for the Plan's decision. Finding 1.2.2: The Plan did not provide translated member information in the identified threshold language for Durable Medical Equipment (DME) denials.

The Plan must ensure delegates comply with all Contract requirements related to delegated functions. The Plan remains fully responsible for the performance of all duties and obligations it delegates. Finding 1.5.1: The Plan must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity for members less than 21 years of age. The Plan did not ensure that American Specialty Health (ASH), the delegate, applied the EPSDT standard of medical necessity to service requests for members under the age of 21.

Category 2 – Population Health Management and Coordination of Care

There were no findings noted in this category during the audit period.

Category 3 – Network and Access to Care

There were no findings noted in this category during the audit period.

Category 4 – Grievances, Appeals, and Member Rights

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. A complaint is the same as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. Finding 4.1.1: The Plan did not identify all member expressions of dissatisfaction as grievances.

The Plan must comply with the 30-calendar-day timeframe for grievance resolution. If a standard grievance is not resolved within 30-calendar-days, the Plan must notify the member in writing of the status of the grievance and the estimated resolution date. Finding 4.1.2: The Plan did not resolve grievances within the required 30-calendar-day timeframe and allowed a 14-calendar-day extension for grievance resolution.

Category 5 – Quality Improvement and Health Equity Transformation Program

There were no findings noted in this category during the audit period.

Category 6 – Plan Administration and Organization

There were no findings noted in this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

DHCS conducted an audit of the Plan from November 3, 2025, through November 14, 2025, for the audit period of November 1, 2024, through December 31, 2025. The audit included a review of the Plan's Contracts with DHCS, policies and procedures for providing services, 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: Sixty-two (32 NCAL and 30 SCAL) medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Requests: Forty-six (18 NCAL and 28 SCAL) prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: Forty-seven (17 NCAL and 30 SCAL) chiropractic and acupuncture authorization requests from ASH were reviewed for timeliness, consistent application of criteria, and appropriate adjudication.

Category 2 – Population Health Management and Coordination of Care

Basic Population Health Management/Population Risk Stratification and Segmentation, and Risk Tiering: Thirty (15 NCAL and 15 SCAL) medical records were reviewed to confirm coordination of care and fulfillment of Population Health Management and Risk Stratification and Segmentation requirements.

California Children's Services: Twenty (10 NCAL and 10 SCAL) medical records were reviewed for evidence of coordination of care between the Plan and California Children's Services providers.

Initial Health Appointment: Twenty (10 NCAL and 10 SCAL) medical records were reviewed for evidence of coordination of care and fulfillment of Initial Health Appointment requirements.

Complex Case Management: Ten (five NCAL and five SCAL) medical records were reviewed to confirm coordination of care.

Behavioral Health Treatment: Ten (five NCAL and five SCAL) medical records were reviewed to confirm coordination of care and fulfillment of behavioral health treatment requirements.

Continuity of Care: Ten (five NCAL and five SCAL) were reviewed to confirm coordination of care and fulfillment of continuity of care requirements.

Enhanced Care Management: Ten (five NCAL and five SCAL) medical records were reviewed to confirm coordination of care and fulfillment of Enhanced Care Management requirements.

Category 3 – Network and Access to Care

Claims: Twenty emergency services (10 NCAL and 10 SCAL) and 20 family planning (10 NCAL and 10 SCAL) claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation: Twenty (10 NCAL and 10 SCAL) claims were reviewed for timeliness and appropriate adjudication.

Non-Medical Transportation: Fourteen (seven NCAL and seven SCAL) claims were reviewed for timeliness and appropriate adjudication.

Category 4 – Grievances, Appeals, and Member Rights

NCAL Grievances: Forty-five grievances, including 29 standard quality of care, 15 standard quality of service, and 1 expedited, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Ten inquiries were also reviewed.

SCAL Grievances: Forty-five grievances, including 27 standard quality of care, 15 standard quality of service, and 3 expedited, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Twenty exempt grievances and 10 inquiries were also reviewed.

Confidentiality Rights: Fifteen (seven NCAL and eight SCAL) Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

Potential Quality Issues: Twenty-six (14 NCAL and 12 SCAL) potential quality issues were reviewed for appropriate evaluation, and effective action was taken to address the needed improvements.

Provider Training: Thirty new provider training records were reviewed for the timeliness of Medi-Cal managed care program training.

Category 6 – Plan Administration and Organization

Fraud and Abuse: Twenty (eight NCAL, nine SCAL, and three NCAL and SCAL) fraud and abuse cases were reviewed for appropriate reporting and processing.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Notice of Actions for Delayed Service Requests (Northern California)

The Plan's failure to render a decision and send a written NOA to the member within the required timeframe is considered a denial of the requested service and therefore constitutes an ABD on the date that the timeframe expires, in accordance with Code of Federal Regulations (CFR), title 42 section 438.404(c)(5). *(Contract, Exhibit A, Attachment III, 4.6.4)*

The Plan must comply with all DHCS guidance, including All Plan Letters (APLs). APLs existing on the effective date of this Contract will be considered part of the Contracts. *(Contract, Exhibit E, 1.1.2(A)(1))*

The Plan must mail the notice of an ABD for service authorization decisions that are not reached within the timeframes specified in CFR, title 42, section 438.210(d), which constitutes a denial and is thus an ABD, on the date that the timeframes expire. *(CFR, title 42, section 438.404(c)(5))*

For standard authorization decisions, the Plan must provide notice within the state-established timeframe, which must not exceed 14-calendar-days after receiving the service request. *(CFR, title 42, section 438.210(d)(1)(i)(A))*

A NOA is defined as a formal letter informing a member of an ABD. The Plan must render a decision for a standard authorization request and notify the member using the appropriate NOA template within the required timeframe of 14-calendar-days after receiving the request. Failure to render a decision for standard authorization requests within the required timeframe is considered a denial and therefore constitutes an ABD on the date that the timeframe expires. The Plan must provide members with written notice of an ABD using the appropriate DHCS-developed, standardized NOA template that accommodates the Plan's action. Types of NOAs include "deny", when the Plan denies a request, and "delay", when the Plan needs more time to decide due to inadequate information and/or additional required steps. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *17.0: Utilization Management (UM) Denial of Practitioner Requested Services* (approved 9/24/24), defines a NOA as a written notification to the member informing them of the service being denied, terminated, modified, or delayed, and provides the specific reason for the determination.

Finding: The Plan did not provide members with a NOA for adverse benefit determinations when it did not render authorization decisions for standard service requests within the required timeframe of 14-calendar-days.

A verification study found that for 6 of 32 service requests, the Plan did not render authorization decisions within the required 14 calendar days.

The six requests were subsequently denied, and a "deny" NOA letter was sent 20 to 35 days after the service request was received.

In addition, the Plan must provide members with notice of an ABD using the NOA template that accommodates the Plan's action, such as the "delay" or "deny" NOA. In five of the six delayed requests, a delay NOA was not sent to the member.

In a written statement, the Plan explained that a delay notification protocol is initiated when a service request lacks sufficient information. The five delayed service requests were not waiting for additional information. In an interview, the Plan clarified that the requests were overdue due to a system issue that did not forward the service request to a physician for review and processing. This protocol was deficient because it did not ensure that NOAs were generated for all ABDs when the Plan did not render timely authorization decisions for service requests.

The Plan's workflow procedure, *Northern California Durable Medical Equipment Work Queue Prioritization Process for Medi-Cal List Referrals* (effective 11/15/23), indicates that for incomplete or ambiguous service requests, "delay" NOAs are only issued if requested information has not been received. This process is deficient as it does not require providing "delay" NOAs to members in all cases when the Plan does not render an authorization decision within the required timeframe, regardless of the reason. Plan policy 17.0 did not provide sufficient guidance to ensure contractual compliance with requirements regarding NOAs.

Not providing members with a NOA when the Plan does not render an authorization decision within the required timeframe deprives members of important information and could adversely affect their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure that members are provided with a NOA for adverse benefit determinations within the required timeframe.

1.2.1 Notice of Actions for Delayed Service Requests (Southern California)

The Plan's failure to render a decision and send a written NOA to the member within the required timeframe is considered a denial of the requested service and therefore constitutes an ABD on the date that the timeframe expires, in accordance with CFR, title 42, section 438.404(c)(5). (*Contract, Exhibit A, Attachment III, 4.6.4*)

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contracts. (*Contract, Exhibit E, 1.1.2(A)(1)*)

The Plan must mail the notice of an ABD for service authorization decisions that are not reached within the timeframes specified in CFR, title 42, section 438.210(d), which constitutes a denial and is thus an ABD, on the date that the timeframes expire. (*CFR, title 42, section 438.404(c)(5)*)

For standard authorization decisions, the Plan must provide notice within the state-established timeframe, which must not exceed 14-calendar-days after receiving the service request. (*CFR, title 42, section 438.210(d)(1)(i)(A)*)

A NOA is defined as a formal letter informing a member of an ABD. The Plan must render a decision for a standard authorization request and notify the member using the appropriate NOA template within the required timeframe of 14-calendar-days after receiving the request. Failure to render a decision for standard authorization requests within the required timeframe is considered a denial and therefore constitutes an ABD on the date that the timeframe expires. The Plan must provide members with written notice of an ABD using the appropriate DHCS-developed, standardized NOA template that accommodates the Plan's action. Types of NOAs include "deny", when the Plan denies a request, and "delay", when the Plan needs more time to decide due to inadequate information and/or additional required steps. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *SC.RUM.016: Utilization Management (UM) Denial of Practitioner-Requested Services* (approved 11/14/24), defines a NOA as a formal letter informing a member of an ABD. An ABD is defined as any of the following seven actions:

- The denial or limited authorization of a requested service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial of payment for a service.
- Failure to provide services in a timely manner.
- Failure to act within the required timeframes for standard resolution of grievances and appeals.
- The denial of a request for services outside the network for a resident of a rural area with only one managed care plan.
- The denial of a member's request to dispute financial liability.

Finding: The Plan did not provide members with a NOA for adverse benefit determinations when it did not render authorization decisions for standard service requests within the required timeframe of 14-calendar-days.

A verification study found that for 4 of 17 service requests, the Plan did not render authorization decisions within the required 14-calendar-days.

The four requests were subsequently denied, and a "deny" NOA was sent 21 to 79 days after the service request was received.

In addition, the Plan must provide members with notice of an ABD using the NOA template that accommodates the Plan's action, such as the "delay" or "deny" NOA. In all four delayed requests, delay NOA letter was not sent to the member.

In an interview and written statement, the Plan explained that "delay" NOAs are only issued when expert review, or additional information or testing is required to render an authorization decision. The four delayed service requests did not meet the Plan's criteria for a delay. The Plan clarified that one request was delayed due to a staff error, and the other three requests were delayed due to a system issue that did not forward the service request to a physician for review and processing. The Plan did not provide an explanation as to why a NOA was not sent to members after the request was adjudicated.

A review of Plan policy *SC.RUM.016* revealed that not rendering an authorization decision for service requests within the required timeframe is not specifically included in the list of actions that the Plan considers an ABD. The Plan's policy did not provide sufficient guidance to ensure contractual compliance with requirements regarding NOAs.

Not providing members with a NOA when the Plan does not render an authorization decision within the required timeframe deprives members of important information and could adversely affect their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure that members are provided with a NOA for adverse benefit determinations within the required timeframe.

1.2.2 Translation of Member Information (Southern California)

The Plan must be able to provide full and immediate translation of written materials for limited English proficiency members who speak threshold or concentration languages and fully translated member information, including member rights information, form letters, and NOAs. (*Contract, Exhibit A, Attachment III, 5.2.10(B)(3)(b)*)

The Plan must ensure that all NOAs are in a language that meets the standards of *APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services* (dated 5/3/22). NOAs must include a fully translated written notice with clinical rationale for the Plan's decision. (*Contract, Exhibit A, Attachment III, 4.6.4(E)(1)*)

The Plan must comply with all DHCS guidance, including all existing and future APLs. APLs existing on the effective date of this Contract will be considered part of the Contracts. APLs cited and incorporated by reference into the Contracts also include any subsequent revisions to the APL. (*Contract, Exhibit E, 1.1.2(A) (1) and (5)*)

APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats (dated 2/12/25), supersedes APL 21-004. Member information is essential information regarding access to and usage of services, including documents that are vital or critical to obtaining services and/or benefits, including form letters and NOAs. The Plan must provide written translations of member information in threshold and concentration languages. (*APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats*)

Member information is essential information regarding access to and usage of services, including documents that are vital or critical to obtaining services and/or benefits, including form letters and NOAs. The Plan must provide written translations of member information in threshold and concentration languages. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan policy, *CA.HP.Operations.LA.005001: Quality Translation Process for Member Informing Materials* (effective 1/1/25), states that the Plan is committed to providing translated vital documents to members in threshold languages as required by state and federal requirements. Vital documents include documents that are vital or critical to obtaining services and/or benefits, form letters, and NOAs. The Plan must provide vital documents in threshold languages for Medi-Cal members.

Finding: The Plan did not provide translated member information in the identified threshold language for denials of DME.

A verification study of 30 cases revealed three were denied DME requests for members whose primary language was Spanish, a threshold language. In all three cases, the NOA, "Your Rights" attachment, Independent Medical Review (IMR) form, State Hearing form, and the Nondiscrimination Notice were not translated into the required threshold language for the members.

In a written statement, the Plan stated that it currently does not provide translated versions of DME notices, NOAs, IMRs, or State Hearing forms. Only the Knox-Keene "Your Rights" attachment and the Nondiscrimination Notice are available in translated formats. However, none of these documents were translated in all three deficient cases in the verification study. The Plan added that members whose preferred language is not English, including threshold languages, receive the documents in English and are required to contact Member Services for translation assistance. The Plan was unable to provide details regarding the origin of the translation deficiency due to the dissolution of the team responsible for DME notices in 2023; the team members are no longer with the Plan. However, the Plan acknowledged that their current process does not provide translated versions of all member information.

Not providing translated member information restricts members' rights and deprives them of important information, which could adversely affect their ability to make informed health care decisions.

Recommendation: Revise and implement procedures to ensure that the Plan provides translated member information in threshold languages for denials of durable medical equipment.

1.5. DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegation Oversight (Northern California)

The Plan must ensure delegates comply with all Contract requirements related to delegated functions. The Plan remains fully responsible for the performance of all duties and obligations it delegates. To ensure compliance, the Plan must monitor and oversee all delegated functions. *(Contract, Exhibit A, Attachment III, 3.1.1(B)(3))*

The Plan must apply the EPSDT standard of medical necessity for members less than 21 years of age, as set forth in APL 23-005, *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21* (dated 3/16/23). The Plan must cover and ensure the provision of all screening, preventive, and medically necessary diagnostic and treatment services for members less than 21 years of age required under the EPSDT benefit described in APL 23-005. *(Contract, Exhibit A, Attachment III, 5.3.2 and 5.3.4)*

For members less than 21 years of age, a service is medically necessary if it meets the EPSDT standard of medical necessity. This includes all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the member's current health condition. The Plan must determine medical necessity based on the individual needs of the child. *(Contract, Exhibit A, Attachment I, 1.0)*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contracts. *(Contract, Exhibit E, 1.1.2(A)(1))*

An EPSDT covered service is medically necessary when it corrects or ameliorates physical and mental illnesses and conditions. The Plan must apply this definition when determining if a service is medically necessary for any member under the age of 21. EPSDT services mean necessary diagnostic services, treatment, and other measures to correct or ameliorate physical and mental illnesses and conditions, whether such services are covered under the state plan. The Plan must ensure that delegates comply with all state and federal laws and regulations, Contract requirements, and APLs. The Plan must communicate EPSDT requirements to its delegates. The Plan must ensure the

delegates' policies, procedures, and practices comply with EPSDT requirements and this APL. (*APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21*)

Plan policy, *28.0: Kaiser Permanente Northern California Delegation of Utilization Management (UM) Activities for Delegated Entities* (approved 6/25/24), states that the Plan's UM Department will evaluate the delegate's UM Program Description, Work Plan, and Program Evaluation annually, and perform an annual desktop audit of the delegate's UM Program to ensure that it complies with all the Plan's regulatory requirements.

Finding: The Plan did not ensure that the delegate, ASH, applied the EPSDT standard of medical necessity for service requests for members under the age of 21.

A verification study of 17 service requests included nine members under 21 years of age. In three of nine, ASH modified the service requests without applying EPSDT standards:

- The delegate denied seven of ten requested chiropractor visits for an 18-year-old member.
- The delegate denied three of four requested chiropractor visits for a 4-month-old member.
- The delegate denied two of eight requested chiropractor visits for a 20-year-old member.

For each request, the delegate's medical necessity determination was based on an internal policy, *Clinical Practice Guideline 278: Chiropractic Services Medical Policy/Guideline* (revised 10/17/24). A review of this policy did not reveal the requirement to apply the EPSDT standard when determining medical necessity for members under the age of 21.

In an interview, ASH stated that reviewers are required to consider EPSDT when appropriate; however, they don't have a step in their process where the reviewer is required to document that they considered EPSDT.

In an interview, the Plan described its annual statewide audit of the delegate, including a file selection process that ensures inclusion of members under the age of 21. The audit reviewed the criteria used by the delegate to authorize services, including the application of the EPSDT standard of medical necessity. However, the Plan's audit documentation did not support its claim that it verified the delegate's use of the EPSDT standard during the review process.

A review of the Plan's statewide delegate audit tool for the 2024 lookback period showed that while the Plan confirmed the delegate had written EPSDT criteria and policies, the audit tool did not require evaluation of the delegate's application of the EPSDT standard. The Plan's 2024 oversight scoring summary assessed four areas—appropriate professionals, timeliness, clinical information, and denial notices—but did not include EPSDT application. In response to a written request for more details, the Plan did not confirm that EPSDT standards were evaluated during file review. Additionally, Plan policy, 28.0 *Kaiser Permanente Northern California Delegation of UM Activities*, did not include a requirement to ensure the appropriate application of EPSDT standards. Therefore, the audit tool and policy lack sufficient guidance to ensure effective oversight of the delegate's use of EPSDT medical necessity criteria for members under the age of 21.

Not providing effective delegation oversight may result in missed opportunities to identify and correct deficiencies in the delegate's practices. Not applying the EPSDT standard of medical necessity for service requests for members under the age of 21 may result in the inappropriate denial of medically necessary services and adversely affect clinical outcomes.

Recommendation: Revise and implement policies and procedures to ensure that delegates apply the EPSDT standard for members under the age of 21.

1.5.1 Delegation Oversight (Southern California)

The Plan must ensure delegates comply with all Contract requirements related to delegated functions. The Plan remains fully responsible for the performance of all duties and obligations it delegates. To ensure compliance, the Plan must monitor and oversee all delegated functions. (*Contract, Exhibit A, Attachment III, 3.1.1(B)(3)*)

The Plan must apply the EPSDT standard of medical necessity for members less than 21 years of age, as set forth in *APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21* (dated 3/16/23). The Plan must cover and ensure the provision of all screening, preventive, and medically necessary diagnostic and treatment services for members less than 21 years of age required under the EPSDT benefit described in APL 23-005. (*Contract, Exhibit A, Attachment III, 5.3.2 and 5.3.4*)

For members less than 21 years of age, a service is medically necessary if it meets the EPSDT standard of medical necessity. This includes all services necessary to achieve or maintain age-appropriate growth and development, attain, regain, or maintain functional capacity, or improve, support, or maintain the member's current health condition. The Plan must determine medical necessity based on the individual needs of the child. *(Contract, Exhibit A, Attachment I, 1.0)*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contracts. *(Contract, Exhibit E, 1.1.2(A)(1))*

An EPSDT covered service is medically necessary when it corrects or ameliorates physical and mental illnesses and conditions. The Plan must apply this definition when determining if a service is medically necessary for any member under the age of 21. EPSDT services mean necessary diagnostic services, treatment, and other measures to correct or ameliorate physical and mental illnesses and conditions, whether such services are covered under the state plan. The Plan must ensure that delegates comply with all state and federal laws and regulations, Contract requirements, and APLs. The Plan must communicate EPSDT requirements to its delegates. The Plan must ensure the delegates' policies, procedures, and practices comply with EPSDT requirements and this APL. *(APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21)*

Plan policy, *SC.RUM.033: Delegation of Utilization Management (UM) Activities* (approved 7/26/24), states the Plan is responsible for ensuring that the delegate can perform the delegated activities in compliance with all state and federal laws and regulations, and Contract requirements. The Plan must oversee delegated activities. The Plan will perform an annual desktop audit of the delegate's UM Program to ensure that it complies with all state and federal laws and regulations, and Contract requirements.

Finding: The Plan did not ensure that the delegate, ASH, applied the EPSDT standard of medical necessity for service requests for members under the age of 21.

A verification study of 30 service requests included two for members under 21 years of age. For both, ASH denied the requests without applying EPSDT standards:

- The delegate denied a request for acupuncture treatment for an 18-year-old member.
- The delegate denied a request for two chiropractor visits for a 10-year-old member.

For the denied acupuncture request, the delegate referenced California Code of Regulations, title 22, section 51308.5, Acupuncture Services. For the denied chiropractic request, the delegate referenced an internal policy, *Clinical Practice Guideline 278: Chiropractic Services Medical Policy/Guideline* (revised 10/17/24). A review of these documents did not reveal the requirement to apply the EPSDT standard when determining medical necessity for members under the age of 21.

In an interview, ASH stated that reviewers are required to consider EPSDT when appropriate; however, they don't have a step in their process where the reviewer is required to document that they considered EPSDT.

In an interview, the Plan described its annual statewide audit of the delegate, including a file selection process that ensures inclusion of members under the age of 21. The audit reviewed the criteria used by the delegate to authorize services, including the application of the EPSDT standard of medical necessity. However, the Plan's audit documentation did not support its claim that it verified the delegate's use of the EPSDT standard during the review process.

A review of the Plan's statewide delegate audit tool for the 2024 lookback period showed that while the Plan confirmed the delegate had written EPSDT criteria and policies, the audit tool did not require evaluation of the delegate's application of the EPSDT standard. The Plan's 2024 oversight scoring summary assessed four areas—appropriate professionals, timeliness, clinical information, and denial notices—but did not include EPSDT application. In response to a written request for more details, the Plan did not confirm that EPSDT standards were evaluated during file review. Additionally, plan policy SC.RUM.033 did not include a requirement to ensure appropriate application of EPSDT standards. Therefore, the audit tool and policy lack sufficient guidance to ensure effective oversight of the delegate's use of EPSDT medical necessity criteria for members under the age of 21.

Not providing effective delegation oversight may result in missed opportunities to identify and correct deficiencies in the delegate's practices. Not applying the EPSDT standard of medical necessity for service requests for members under the age of 21 may result in the inappropriate denial of medically necessary services and adversely affect clinical outcomes.

Recommendation: Revise and implement policies and procedures to ensure that delegates apply the EPSDT standard for members under the age of 21.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance Identification (Northern and Southern California)

The Plan must have a member Grievance and Appeal system in accordance with CFR, title 42, section 438.402-424. (*Contract, Exhibit A, Attachment III, 4.6.1*)

The Plan is required to comply with all DHCS guidance, including APLs. (*Contract, Exhibit E, 1.1.2*)

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. A complaint is the same as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. (*APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *CA.MR.003 California Non-Medicare Grievance and Appeals* (revised 4/23/25), states inquiries are "any oral or written request for any information, clarification, or assistance that is not associated to an expression of dissatisfaction or request for service or payment." Standard grievances are, "an expression of dissatisfaction about any matter other than an adverse benefit determination."

Finding: The Plan did not identify all member expressions of dissatisfaction as grievances.

A verification study found that in 7 of 20 inquiries, the Plan incorrectly processed the grievances as member inquiries. The Plan did not conduct formal grievance investigations into these misclassified member complaints.

- In six inquiries, members complained of receiving a bill for services from out-of-network providers. Members had no financial responsibility. The Plan either cancelled or paid the remaining balance to the out-of-network provider.
- In one inquiry, a member complained of receiving an explanation of benefits for an ambulance service they did not request nor receive. The Plan's investigation revealed the claim was processed under an incorrect medical record number.

Although the Plan did not consider or classify the expressions of dissatisfaction as grievances, it investigated and submitted resolution letters with grievance “Your Rights”, Nondiscrimination Notice attachments, and Notice of Language Assistance Taglines in three of the seven inquiries.

The Plan provided conflicting statements regarding how it handles member billing issues. In interviews, the Plan confirmed that requests for financial resolution cannot be considered inquiries, and any inquiry with an expression of dissatisfaction is to be processed as a grievance.

In a written statement, the Plan confirmed that six samples relate to member billing from non-Plan providers. The Plan stated that member billing disputes are not processed as grievances against the Plan, as these inquiries do not include any expression of dissatisfaction with the Plan. However, Plan policy CA.MR.003 identified payment or billing issues as an expression of dissatisfaction. Therefore, the Plan should have classified and processed these complaints as grievances.

The Plan’s process did not comply with the APL, which does not require the Plan to determine to whom the member’s expression of dissatisfaction is directed towards in classifying an inquiry versus a grievance. Inquiries do not include expression of dissatisfaction.

When member expressions of dissatisfaction are not identified and processed as grievances, members will not receive notice of members’ rights, and their complaints may not be fully investigated and resolved.

Recommendation: Implement procedures to ensure all member expressions of dissatisfaction are identified as grievances.

4.1.2 Grievance Resolution Extensions (Northern and Southern California)

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contracts. (*Contract, Exhibit E, 1.1.2(A)(1)*)

APL 21-011, Grievance and Appeal Requirements, Notice and “Your Rights” Templates supersedes *APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments* (dated 5/9/17). Even though federal regulations allow for a 14-calendar-day extension for appeals, this allowance does not apply to grievances. The Plan must comply with the 30-calendar-day timeframe for

grievance resolution. If a standard grievance is not resolved within 30-calendar-days, the Plan must notify the member in writing of the status of the grievance and the estimated resolution date. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Federal regulations allow for a 14-calendar-day extension for appeals. This allowance does not apply to grievances. The Plan must comply with the 30-calendar-day timeframe for grievance resolution. If a standard grievance is not resolved within

30-calendar-days, the Plan must notify the member in writing of the status of the grievance and the estimated resolution date, which must not exceed 14-calendar-days. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments*)

Plan policy, *CA.MR.003: California Non-Medicare Grievance and Appeals* (revised 1/8/25), states that extensions are not allowed for grievances. If a grievance resolution cannot be provided within 30 days, the member must be notified in writing of the expected resolution timeframe.

Finding: The Plan did not resolve grievances within the required 30-calendar day timeframe and allowed a 14-calendar-day extension for grievance resolutions.

The verification study revealed that 10 of 56 standard grievances were not resolved within the required 30-day timeframe and thus required written notices informing the members of the status of their grievance and an estimated resolution date. The delays ranged from 2 to 29 days. In all cases, the Plan informed the member to expect a written response in 14-calendar-days, despite the Contracts prohibiting the use of

14-calendar-day extensions. Despite resolving 9 of the 10 delayed grievances within eight days or less of the original resolution due date, the Plan remained contractually noncompliant because it allowed 14-calendar-day extensions. Additionally, the Plan provided a predetermined and inaccurate date to expect a written response, rather than an estimated resolution date based on the status of each member's grievance, as required by the Contracts.

In a written statement and during an interview, the Plan explained that the 14-day timeframe for delayed grievance resolution originated from APL 17-006, which states that the estimated resolution date must not exceed 14 calendar days. The Plan added that although this timeframe was removed in APL 21-011, there was still a requirement to notify members of an estimated resolution date. Therefore, the Plan continued to utilize the 14-calendar-day benchmark previously established by DHCS in APL 17-006.

However, this rationale is incorrect, as the 14-calendar-day timeframe referred to in APL 17-006 is the timeframe that must not be exceeded for the estimated resolution date of individual delayed grievances. It is not a standard established by DHCS for the estimated timeframe for all delayed grievance resolutions. APL 17-006 and APL 21-011 both state that 14-calendar-day extensions are not allowed for grievances.

In a written statement, the Plan clarified that policy *CA.MR.003* does not include the 14-calendar-day timeframe that the Plan allows for all delayed grievance resolutions because the policy was written to align with APL 21-011, which does not specify a timeframe for delayed grievance resolution. Also, the Plan explained that it does not consider the 14-day timeframe an extension because extensions allow for a justifiable reason for resolving a grievance beyond the required timeframe, and thus would not be considered untimely, and grievances that are resolved after the required timeframe are documented and tracked as untimely. However, this rationale is incorrect because any resolution beyond the required timeframe is untimely, regardless of the reason.

The Plan added that providing a unique estimated resolution date for each delayed grievance is a significant challenge, as the specific reasons for delays are varied and unpredictable. Using a standard, 14-calendar-day estimate provides consistent messaging and mitigates frustrations that may result from under-approximating estimates. Nonetheless, 14-calendar-day extensions for grievance resolution are not allowed, and the Plan is contractually required to notify the member in writing of the status of the grievance and the estimated resolution date.

Allowing predetermined 14-calendar-day extensions for grievance resolution could delay the provision of important information to members and adversely affect their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure that the Plan resolves grievances within the required 30-calendar-day timeframe and does not allow 14-calendar-day extensions for grievance resolution.

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN FRANCISCO SECTION

**REPORT ON THE MEDICAL AUDIT OF
KAISER FOUNDATION HEALTH PLAN, INC.
2025**

Contract Numbers:

23-30259 – Single Plan

23-30260 – Geographic Managed Care

23-30261 – Two-Plan

23-30262 – Regional

23-30263 – County Organized Health System

Contract Type: State Supported Services

Audit Period: November 1, 2024 — December 31, 2025

Dates of Audit: November 3, 2025 — November 14, 2025

Report Issued: April 17, 2026

TABLE OF CONTENTS

I. INTRODUCTION 3

II. COMPLIANCE AUDIT FINDINGS 4

I. INTRODUCTION

This report presents the results of the audit of Kaiser Foundation Health Plan, Inc. (Plan) compliance and implementation of the following State Supported Services contracts with the State of California:

KP Cal, LLC.

07-65850 – Sacramento

09-86160 – San Diego

Kaiser Foundation Health Plan, Inc.

23-30259 – Single Plan

23-30260 – Geographic Managed Care

23-30261 – Two-Plan

23-30262 – Regional

23-30263 – County Organized Health System

The State Supported Services Contracts cover abortion services under the Plan.

The audit covered the period of November 1, 2024, through December 31, 2025. The audit was conducted from November 3, 2025, through November 14, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

Twenty claims (10 Northern California and 10 Southern California) were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held on February 26, 2026. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under these Contracts or the Primary Contracts, the following private services:

- 1) Current Procedure Terminology codes 59840 through 59857
- 2) Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336

These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transactions and code set provisions. (*2023 Hyde Contract, Exhibit A, (1) and 2024 Hyde Contract, Exhibit A, 1.2.1*)

The Plan is required to cover abortion services, the medical services, and supplies incidental or preliminary to an abortion, consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers, and subcontractors are prohibited from requiring medical justification, imposing any utilization management, or utilization review requirements, including prior authorization, for the coverage of outpatient abortion services. (*All Plan Letter, 24-003, Abortion Services*)

Finding: No deficiencies were identified in the audit.

Recommendation: None.