DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF KAISER FOUNDATION HEALTH PLAN, INC. FISCAL YEAR 2024-25

Contract Numbers:

KP Cal, LLC.

07-65849 – Sacramento

09-86159 – San Diego

Kaiser Foundation Health Plan, Inc.

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, 2023 — October 31, 2024

Dates of Audit: November 12, 2024 — November 22, 2024

Report Issued: April 24, 2025

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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 Kaiser's 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 to delegate 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 Northern California (NCAL), and Southern California (SCAL) regions. As of October 31, 2024, the Plan served approximately 1,137,034 (487,064 NCAL and 649,970 SCAL) Medi-Cal members in the following counties:

NCAL: Alameda (69,879), Contra Costa (55,113), Marin (6,760), Napa (7,309), Solano (37,473), Sonoma (25,446), Yolo (5,500), Sacramento (133,614), Amador (305), Placer (17,358), El Dorado (4,006), San Francisco (20,972), San Mateo (15,373), Santa Clara (45,480), Fresno (7,161), Kings (154), Madera (1,203) , San Joaquin (25,519), Stanislaus (7,035), Santa Cruz (589), Tulare (54), Mariposa (11), Sutter (25), and Yuba (725).

SCAL: Orange (68,209), San Diego (73,322), Riverside (86,153), San Bernardino (92,283), Los Angeles (301,293), Kern (20,729), Ventura (7,958), Imperial (20), and Tulare (3).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of November 1, 2023, through October 31, 2024. The audit was conducted from November 12, 2024, through November 22, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

The audit evaluated five categories of performance: Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of November 1, 2022, through October 31, 2023, was issued on March 19, 2024. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation of the prior year 2023, 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

Utilization Management was not reviewed for the audit period.

Category 2 – Population Health Management and Coordination of Care

SCAL

The Plan must cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in California Code of Regulations (CCR), Title 17, sections 37000 – 37100, and in accordance with *All Plan Letter (APL) 20-016, Blood Lead Screening of Young Children*. Finding 2.1.1: The Plan did not ensure the provision of blood lead screenings for members under six years of age.

For members less than 21 years of age, the Plan must cover medically necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with *APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members*

Under the Age of 21. Finding 2.3.1: The Plan did not ensure the provision of BHT services for members under 21 years of age.

The Plan must complete Continuity of Care (COC) requests within 30 calendar days for non-urgent requests. Finding 2.4.1: The Plan did not ensure that COC requests from members were completed within the required timelines.

NCAL and SCAL

The Plan must use the current American Academy of Pediatrics (AAP)/Bright Futures Periodicity Schedule and guidelines when delivering care to any member under the age of 21. Finding 2.7.1: The Plan did not ensure members received Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits in accordance with the AAP/Bright Futures Periodicity Schedule.

Category 3 – Network and Access to Care

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

Category 4 – Member Rights

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

Category 5 – Quality Improvement and Health Equity Transformation

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

Category 6 –Administrative and Organizational Capacity

There were no findings noted for 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 Contract.

PROCEDURE

DHCS conducted an audit of the Plan from November 12, 2024, through November 22, 2024, for the audit period of November 1, 2023, through October 31, 2024. 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 Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Utilization Management was not reviewed for the audit period.

Category 2 – Population Health Management and Coordination of Care

Basic Population Health Management/Population Risk Stratification and Segmentation, and Risk Tiering: Twenty-four (12 NCAL and 12 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: Thirteen (five NCAL and eight SCAL) were reviewed for evidence of coordination of care between the Plan and California Children's Services providers.

Initial Health Appointment: Thirty-seven (17 NCAL and 20 SCAL) medical records were reviewed for evidence of coordination of care and fulfillment of Initial Health Appointment requirements.

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

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

COC: Twelve (six NCAL and six SCAL) were reviewed to confirm coordination of care and fulfillment of COC requirements.

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

EPSDT: Forty (20 NCAL and 20 SCAL) were reviewed to confirm coordination of care and fulfillment of EPSDT requirements.

Category 3 – Network and Access to Care

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

Non-Emergency Medical Transportation: Thirty (15 NCAL and 15 SCAL) claims were reviewed for timeliness and appropriate adjudication.

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

Category 4 – Member Rights

NCAL Grievances: Twenty-five grievances, including 15 standard quality of service (non-clinical) grievances and 10 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Ten inquiries were also reviewed.

SCAL Grievances: Twenty-five grievances, including 15 standard quality of service (non-clinical) grievances and 10 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Ten inquiries were also reviewed.

Category 5 – Quality Improvement and Health Equity Transformation

There were no verification studies conducted for the audit review.

Category 6 – Administrative and Organizational Capacity

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

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 Initial Health Appointment

2.1.1 Provision of Blood Lead Screening (Southern California)

The Plan shall cover and ensure the provision of a blood lead screening test to members at ages one and two in accordance with CCR, Title 17 Division 1, Chapter 9, section 37000. The Plan shall document and appropriately follow up on blood lead screening test results. The Plan shall cover and ensure the blood lead screen test is provided and shall document attempts to provide the test in the member's medical record. (2023 *Contract, A20, Exhibit A, Attachment 10 (5)(D))*

The Plan must cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in CCR, Title 17, sections 37000 – 37100, and in accordance with *APL 20-016, Blood Lead Screening of Young Children*. The Plan must ensure the network providers follow the Childhood Lead Poisoning Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local Public Health Department. *(2024 Contract, Exhibit A, Attachment III, 5.3.4 (D)(1))*

The Plan must identify, at least quarterly, all members less than six years of age with no record of receiving a required blood lead screening test. The Plan must identify the age(s) at which a required blood lead screening test was missed, including members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, the Plan must notify the network provider responsible for the care of an identified member of the requirement to test the member and provide the written or verbal anticipatory guidance as required pursuant to CCR, Title 17, section 37100. *(2024 Contract, Exhibit A, Attachment III, 5.3.4 (D)(2))*

A member's refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the member's medical record as described in Exhibit A, Attachment III, Section 5.3 (Scope of Services). *(Contract, Exhibit A, Attachment III, 5.2.14, (G)(4)(k))*

The Plan is required to ensure that their network providers (physicians, nurse practitioners, and physician's assistants) who perform periodic health assessments on child members between the ages of six months to six years (72 months) comply with current federal and state laws, and industry guidelines for health care providers issued by the Childhood Lead Poisoning Prevention Branch, including any future updates or amendments to these laws and guidelines. The Plan must ensure that the network provider documents the reason(s) for not performing the blood lead screening test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children)*

Plan policy, *NCAL.MEDI APL 20-016 Blood Lead Screening Requirements for Young Children* (effective 1/1/24), stated that the Plan ensures that providers order or perform blood lead screening tests on all child members in accordance with the following:

- When the provider performing assessment becomes aware that a child who is 12 to 24 months of age, has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
- Whenever a provider performing an assessment of a child who is 12 to 72 months of age has no documented evidence of a blood lead screening test taken.

The Plan ensures that providers document the reason(s) for not performing a blood lead screening test in the child's medical record. The Plan's providers will document and appropriately follow up on blood lead screening test results. All providers will make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test. Documented attempts that demonstrate providers' unsuccessful efforts to provide the blood lead screen test shall be considered evidence of meeting this requirement.

Finding: The Plan did not ensure the provision of blood lead screenings for members under six years of age.

A verification study of 20 initial health appointments and 20 well child visits, covering 24 members revealed that 3 samples did not contain documentation of blood lead screening tests or documentation of members refusal.

- In one sample, the case file did not contain documentation of a blood lead screening test or the member's refusal. In a written response, the Plan stated that during a well child visit, the member's parent had responded negatively [answered no] to questions regarding lead paint risk, which ruled out the necessity for blood lead screening. However, there was no documentation from

the provider stating that a blood lead test was not indicated. Additionally, documentation from the same well child visit noted a missing care gap and that a lead test was due. The physician was notified, however, there was no test ordered.

- In another sample, the member did not complete a blood lead screening test during the audit period. The case file did not contain documentation of the provider's outreach attempts to the member to complete the blood lead testing. The case file did not contain documentation of the member's refusal.
- In a third sample, the member did not complete a blood lead screening test during the audit period. While the provider had initially ordered a blood lead screening test shortly after member enrollment with the Plan, the order was cancelled two months later when the test was not completed. The blood lead screening test was not reordered and there was no provider follow-up documented for the member. No member refusal was documented in the case file.

A review of the Plan's Providers Quick Reference Guide stated that the Plan requires providers to screen children enrolled in Medi-Cal for elevated blood lead levels as part of required prevention services offered through the EPSDT program.

A review of the Plan policy showed the Plan's process utilizes claims forms to report blood lead screening to DHCS. While the policy described the reporting requirements, it did not detail the monitoring process for ensuring providers documented members refusals or follow up for blood lead screening.

The Plan submitted a written response that stated members who do not complete their blood lead screening after it has been ordered, reminders are sent via email at three month intervals. After six months, if the blood lead screening remains incomplete, the member is re-added to the notification list, and reminders are sent again via email, letter, and text message. Additionally, at any office visit with an incomplete lead order, providers remind members and encourage them to complete the screening test. However, this process was not reflected in the three samples with missing blood lead screening tests.

When the Plan does not ensure blood lead screening tests for members are completed and documented, medically necessary care and interventions may not be conducted for members with elevated lead levels.

Recommendation: Revise and implement policies and procedures to ensure members under six years of age receive blood lead screening tests.

2.3 Behavioral Health Treatment

2.3.1 Provision of Behavioral Health Treatment Services (Southern California)

The Plan shall provide medically necessary BHT services as stated in the member's treatment plan and/or continuation of BHT services under COC with the member's BHT provider. *(2023 Contract, Exhibit A, Attachment 10 (5)(G)(1))*

For members less than 21 years of age, the Plan must cover medically necessary BHT services regardless of diagnosis in compliance with *APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21*. *(2024 Contract, Exhibit A, Attachment III (F))*

For members under the age of 21, the Plan is required to provide and cover, or arrange, as appropriate, all medically necessary EPSDT services, including BHT services, when they are covered under Medicaid. BHT services must be provided, observed, and directed under a Plan approved behavioral treatment plan. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. The Plan must not limit BHT services based on school attendance or other categorical exclusions. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21)*

Plan policy, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)* (effective 1/1/24), outlines the Plan's approach to adhere to EPSDT services, as required by *APL 23-005*, *Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21*. Through EPSDT, the Plan ensures the provision of all screening, preventive, and medically necessary diagnostic and treatment services and provides medically necessary BHT services, consistent with the requirements of APL 23-010, for all members under the age of 21.

Plan policy, *SC. HPHO.071 Responsibilities for Behavioral Health Treatment Coverage for Medi-Cal Members Under the Age of 21* (effective 8/30/23), stated that the Plan will provide and cover, or arrange, as appropriate, all medically necessary EPSDT services, including BHT services when they are covered under Medicaid. The Plan has primary responsibility to provide all medically necessary BHT services as outlined in the Plan's approved treatment plan.

Finding: The Plan did not ensure the provision of BHT services for members under 21 years of age.

A verification study demonstrated that in three of five samples, the Plan did not provide BHT services as authorized for the BHT plans.

- In one sample, the Plan stated that the member was authorized up to 744 hours and utilized 284 hours during the audit period. However, 460 authorized hours were not provided to the member as approved in the treatment plan. While the family had some cancellations, the provider had cancelled more hours than the family during this authorization period. For example, the family cancelled 16 hours, but the provider cancelled 23 hours during a 6 month authorization period.
- In another sample, the member's treatment plan noted that goals were placed on hold or not introduced due to changes in the clinical teams. In a written response, the Plan stated that the member's family goals were held due to changes in the clinical team and to allow for transition between clinicians. The member's subsequent six month BHT plan also noted that direct hours were lower than requested due to turnover of therapists and difficulty with staffing. While the family cancelled 13 hours, the provider cancelled 77 hours during this six month authorization period. The Plan stated in a written response that the member was authorized to receive up to 1198 hours, but utilized 520 hours during the audit period.
- In a third sample, the provider canceled ten hours of one-to-one during one authorization period but did not offer alternative times to the family.

A review of the Plan's *Regional Autism Spectrum Disorder/Developmental Disabilities Quality and Access Report*, dated January 2024, showed member barriers to services which included a continued lack of available providers in all areas.

In a written response, the Plan provided a comparison between the authorized hours and the utilized hours which showed members did not receive all or even most of the authorized hours in accordance with their BHT plans. The Plan stated that no specific patterns of cancellations by the providers were identified or reported during the audit period. Staff members were noted to be unavailable due to leave, personal reasons, and training. The Plan did not provide information about how it addressed staffing unavailability or corrective actions taken to address the barriers the Plan identified through its monitoring activities.

When the Plan does not ensure members receive BHT services, members may not receive treatment to improve or maintain their behavioral health conditions.

Recommendation: Implement procedures to ensure that members receive BHT services according to their approved BHT plans.

2.4 Continuity of Care

2.4.1 Continuity of Care Request Completion Timeline (Southern California)

The Plan must deliver quality care that enables all members to maintain health and improve or manage a chronic illness or disability. The Plan must ensure quality care in each of the following areas: COC and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships. *(Contract, Exhibit A, Attachment III, 2.2 (A)(6))*

The Plan must maintain policies and procedures that ensures efficient care coordination and COC for members who may need or are receiving services and/or programs from out-of-network providers. *(Contract, Exhibit A, Attachment III, 4.3.8 (5))*

The Plan must process COC requests by following the requirements outlined below; the COC process begins when the Plan receives the COC requests. The Plan must begin to process non-urgent requests within five working days following the receipt of the COC request. Additionally, each COC request must be completed within the following timelines from the date the Plan received the request: 30 calendar days for non-urgent requests; 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or as soon as possible, but no longer than 3 calendar days for urgent requests. *(APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care From Medi-Cal Fee-For-Service, On Or After January 1, 2023)*

Plan policy, *MCAL COC Medi-Cal Continuity of Care Requirements* (effective 1/1/23), stated that each COC request will be completed within the following timelines from the date the Plan received the request: 30 calendar days for non-urgent requests, 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs, or as soon as possible, but no longer than 3 calendar days for urgent requests.

Finding: The Plan did not ensure that COC requests from members were completed within required timelines.

A verification study revealed that three of six routine COC requests were not completed within 30 days. The COC completion times had been delayed between 54 and 86 days.

In a written response, the Plan stated that 47.5 percent of all COC requests during the audit period had exceeded the time limits from DHCS. The Plan also stated some of the files from the members that transitioned were incomplete or incorrect which had caused delays in some cases. The Plan stated widespread delays were due to misinterpretation of the timeframe for transitioned members. The Plan further stated it had misinterpreted the timeframe as providing additional time to process COC requests for transitioned members beyond required timeframes.

When the Plan does not ensure that COC requests are completed within the required timeframes, members may experience delays in receiving medically necessary services to maintain or improve health outcomes.

Recommendation: Implement policies and procedures to ensure members' COC requests are completed within required timelines.

2.7 Early and Periodic Screening, Diagnostic, and Treatment Requirements

2.7.1 Early and Periodic Screening, Diagnostic, and Treatment Requirements (Northern California)

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. The EPSDT benefit includes all medically necessary health care, diagnostic services, treatments, and other services listed in United States Code, Title 42, section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are covered services unless expressly excluded under the Contracts.

The Plan must provide preventive health visits for all members less than 21 years of age at times specified by the most recent Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the Bright Futures Periodicity Schedule. The Plan must provide, as part of the periodic preventive visit, all age-specific assessments and services required by Bright Futures Periodicity Schedule/AAP. *(Contract, Exhibit A, Attachment III, 5.3.4)*

The Plan must identify members who have not utilized EPSDT screening services or Bright Futures Periodicity Schedule/AAP preventive services, and ensure outreach to these members. *(Contract, Exhibit A, Attachment III, 2.2.10, (A)(2)(3))*

For members under the age of 21, Plans must provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law specific to EPSDT. This includes the contractual obligation to provide EPSDT in accordance with the AAP/Bright Futures Periodicity Schedule.

The Plan must use the current AAP/Bright Futures Periodicity Schedule and guidelines when delivering care to any members under the age of 21, including but not limited to health and developmental screening services, physical examination, dental services, vision services, and hearing services. Plans must provide all age-specific assessments and services required by the Contracts and the AAP/Bright Futures Periodicity Schedule. *(APL 23-005 Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age Of 21)*

The *2024 AAP/Bright Futures Periodicity Schedule,* stated that early childhood visits are recommended at ages of 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, and 4 years. The components of the visits include a physical exam, developmental and behavioral screenings, oral health, and anticipatory guidance.

Plan policy, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)* (effective 1/1/24), stated that the Plan uses a Periodicity Schedule and guidelines derived in consideration of the Bright Futures work of the AAP when delivering the EPSDT benefit. The Plan provides all age-specific assessments and services required by the Contracts with DHCS and the Periodicity Schedule and guidelines derived in consideration of the Bright Futures work of the AAP.

Finding: The Plan did not ensure members received EPSDT benefits in accordance with the AAP/Bright Futures Periodicity Schedule.

In a verification study, 6 of 20 samples revealed that the Plan did not ensure members under 21 years of age received EPSDT benefits in accordance with the AAP/Bright Futures Periodicity Schedule. A review of medical records showed:

- In one sample, the 15 month well child visit was not offered or provided.
- In four samples, the 30 month well child visit were not offered or provided.
- In one sample, there was no documentation of any well child visits for a member aged 30 months.

A review of the Plan's Provider Manual, stated that the Plan uses the Bright Futures Periodicity Schedule guidelines for pediatric preventive care and screenings built into the Plan's electronic health record systems. Under the EPSDT program, the Plan must

provide comprehensive screening, vision, dental, and hearing services at intervals that meet standards of medical/dental practice and as medically necessary.

In an interview, the Plan stated that they adhere to the recommendations of the AAP/Bright Futures Periodicity Schedule. The Plan explained that sometimes there can be variations from the Periodicity Schedule where appropriate and a lot of clinical judgement is inferred as well. Furthermore, the Plan stated that there may be occasional divergence from the Bright Futures Periodicity Schedule recommendations. Review of the sample records did not demonstrate that the Plan followed the Bright Futures Periodicity Schedule or that providers documented any divergence from the schedule.

When the Plan does not ensure the provision of all screening, preventive and medically necessary diagnostic and treatment services for members less than 21 years of age, members may not receive important behavioral, medical health, and developmental screenings that can help identify and prevent illnesses.

Recommendation: Implement policies and procedures to ensure that members receive EPSDT benefits in accordance with AAP/Bright Futures Periodicity Schedule guidelines.

2.7.1 Early and Periodic Screening, Diagnostic, and Treatment Requirements (Southern California)

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. The EPSDT benefit includes all medically necessary health care, diagnostic services, treatments, and other services listed in United States Code, Title 42, section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are covered services unless expressly excluded under the Contracts.

The Plan must provide preventive health visits for all members less than 21 years of age at times specified by the most recent Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the Bright Futures Periodicity Schedule. The Plan must provide, as part of the periodic preventive visit, all age-specific assessments and services required by Bright Futures Periodicity Schedule/AAP. *(Contract, Exhibit A, Attachment III, 5.3.4)*

The Plan must identify members who have not utilized EPSDT screening services or Bright Futures Periodicity Schedule/AAP preventive services and ensure outreach to these members. *(Contract, Exhibit A, Attachment III, 2.2.10, (A)(2)(3))*

For members under age 21, the Plan must provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law specific to EPSDT. This includes the contractual obligation to provide EPSDT in accordance with the AAP/Bright Futures Periodicity Schedule.

The Plan must use the current AAP/Bright Futures Periodicity Schedule and guidelines when delivering care to any member under the age of 21, including but not limited to health and developmental screening services, physical examination, dental services, vision services, and hearing services. The Plans must provide all age-specific assessments and services required by the Plan's Contracts and the AAP/Bright Futures Periodicity Schedule. *(APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age Of 21)*

The *2024 AAP/Bright Futures Periodicity Schedule,* stated that early childhood visits are recommended at ages of 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, and 4 years. The components of the visits include a physical exam, developmental and behavioral screenings, oral health, and anticipatory guidance.

Plan policy, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)* (effective 1/1/24), stated that the Plan uses a Periodicity Schedule and guidelines derived in consideration of the Bright Futures work of the AAP when delivering the EPSDT benefit. The Plan provides all age-specific assessments and services required by the Contracts with DHCS and the Periodicity Schedule and guidelines derived in consideration of the Bright Futures work of the AAP.

Finding: The Plan did not ensure members received EPSDT benefits in accordance with the AAP/Bright Futures Periodicity Schedule.

In a verification study, 3 of 20 samples revealed that the Plan did not ensure members under 21 years of age received EPSDT benefits in accordance with the AAP/Bright Futures Periodicity Schedule. In three samples, the 30 month well child visit was not offered or provided. All three sample files contained a note from the 24 month (2 year) well child visit stating the member should return in a year for the 36 month (3 year) visit. There was no documentation to return for the 30 month visit or that it was not needed for the member. Additionally, the case files did not contain documentation of outreach attempts to provide the 30 month visit.

A review of the Plan's Provider Manual, stated that the Plan uses the Bright Futures Periodicity Schedule guidelines for pediatric preventive care and screenings built into

the Plan's electronic health record systems. Under the EPSDT program, the Plan must provide comprehensive screening, vision, dental, and hearing services at intervals that meet standards of medical/dental practice and as medically necessary.

In written responses, the Plan stated it did not experience any barriers to care delivery or access to care regarding well child visit completion during the audit period. The Plan stated that preventive care services and follow ups are scheduled in advance, ensuring COC in accordance with recognized professional standards. However, the Plan did not explain why the providers did not follow the required AAP/Bright Futures Periodicity Schedule.

When the Plan does not ensure the provision of all screening, preventive and medically necessary diagnostic, and treatment services for members less than 21 years of age, members may not receive important behavioral, medical health, and developmental screenings that can help identify and prevent illnesses.

Recommendation: Implement policies and procedures to ensure that members receive EPSDT benefits in accordance with AAP/Bright Futures Periodicity Schedule guidelines.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF KAISER FOUNDATION HEALTH PLAN, INC. FISCAL YEAR 2024-25

Contract Numbers:

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

Contract Type: State Supported Services

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: November 12, 2024 — November 22, 2024

Report Issued: April 24, 2025

TABLE OF CONTENTS

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 with the Plan.

The audit covered the period of November 1, 2023, through October 31, 2024. The audit was conducted from November 12, 2024, through November 22, 2024, which consisted of a document review and verification study with the Plan administration and staff.

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

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 this Contract or the Primary Contract, 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 transaction 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.