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

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

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

Audit Period: September 1, 2019
Through
October 31, 2021

Report Issued: March 3, 2022

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I. INTRODUCTION

Kaiser Foundation Health Plan, Inc. (KFHP) obtained its Knox-Keene license in November 1977 and contracted with the Department of Health Care Services (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 (Plan) was created and licensed as a Knox-Keene plan to hold Kaiser's GMC Contracts. DHCS then transferred the GMC Contracts to the Plan. At that time, the Plan 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 Plan members through KFHP's network of providers and medical centers. KFHP offers a comprehensive health care delivery system including physicians, medical centers, hospitals, laboratories, and pharmacies.

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

As of October 2021, KFHP's total direct GMC Contract membership was approximately 179,730. Medi-Cal membership composition was 119,327 for GMC Sacramento and 60,403 for GMC San Diego.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of September 1, 2019 through October 31, 2021. The review was conducted from November 1 through November 12, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on February 11, 2022. The Plan was allowed to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit (for the period of September 1, 2018 through August 31, 2019) was issued on January 17, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

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

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

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 covers procedures and requirements for the Plan's UM program, including prior authorization review and the appeal process.

Sacramento and San Diego GMC

For members under the age of 21, Plans are required to provide and cover all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental conditions. The Plan did not provide EPSDT services when medically necessary to correct or ameliorate conditions and utilized criteria that were more restrictive than Medi-Cal EPSDT guidelines described in All Plan Letter (APL) 19-010.

Sacramento GMC

The Plan is required to ensure that the UM program includes the integration of UM activities into the Quality Improvement System (QIS). The Plan did not show evidence of integration of UM activities into the Plan's designated Medi-Cal QIS, including a process to integrate reports on the number and types of appeals, denials, deferrals, and modifications to the appropriate Medi-Cal quality improvement staff.

For prior authorization decisions based in whole or in part on medical necessity, the written Notice of Action (NOA) must contain a description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that supports the decisions, as well as an explanation of the criteria or guideline. The Plan did not include a reference to the specific criteria or guidelines used to support medical necessity decisions within NOA letters.

San Diego GMC

The Plan is required to provide, at a minimum, fully translated member information, including but not limited to the member services guide, welcome packets, marketing information and form letters including NOA letters and grievance and appeal acknowledgement and resolution letters. The Plan is required to provide translated written informing materials to all monolingual or limited English-proficient members that speak the identified threshold or concentration standard languages. The Plan did not translate member information in a NOA letter packet into the required threshold and/or concentration language.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to ensure coordination of care.

Sacramento and San Diego GMC

The Plan is required to issue a notice to every member under the age of 21 for whom it has currently authorized Private Duty Nursing (PDN) services. The Plan did not issue a notice to members under the age of 21 for whom it has authorized PDN services in accordance with APL 20-012.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for medically necessary services, and the adjudication of claims for family planning services.

Sacramento and San Diego GMC

The Plan shall not improperly deny or contest a claim or portion thereof. The Plan improperly denied family planning services based on its adjudication of other services submitted on the same claim.

The Plan is required to ensure its network providers are enrolled in Medi-Cal, and may execute network provider agreements pending the outcome of the provider's enrollment up to 120 days, but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider. The Plan did not verify the outcome of the NMT provider's enrollment after 120 days from enrollment application date. The Plan did not terminate the un-enrolled NMT provider after 120 days.

San Diego GMC

The Plan is required to directly pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013. The Plan did not distribute timely add-on payments for specified family planning claims according to APL 20-013.

The Plan is required to ensure its network providers are enrolled in Medi-Cal, and may execute network provider agreements pending the outcome of the provider's enrollment up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider. The Plan did not verify the outcome of the NEMT provider's enrollment after 120 days from enrollment application date. The Plan did not terminate the un-enrolled NEMT provider after 120 days. The Plan did not verify the NEMT provider's enrollment after 120 days from Contract date.

Category 4 – Member's Rights

Category 4 includes requirements for the handling of grievances and Protected Health Information (PHI).

Sacramento and San Diego GMC

The Plan is required to provide written acknowledgement to the member that is dated within five calendar days of receipt of the grievance. The Plan did not provide members with written acknowledgment within five calendar days of receipt of a standard grievance.

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of a standard grievance.

The Plan is required to provide oral notice of the resolution of an expedited review within 72 hours. The Plan did not provide oral resolution to the member within the required 72-hour timeframe for expedited grievances.

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

The Plan is required to ensure that the person making the final decision for the proposed resolution has clinical expertise in treating a member's condition or disease if deciding on any grievance or appeal involving clinical issues. A person with clinical expertise in treating a member's condition did not make the final resolution decision for grievances with clinical issues.

San Diego GMC

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. However, in the event that resolution of a standard grievance is not reached within 30 calendar days as required, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution, which should not exceed 14 calendar days. The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days.

The Plan is required to provide a complete investigation report to DHCS within ten working days upon the discovery of a breach of unsecured PHI or Protected Information (PI) in any 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. The Plan did not submit complete investigation reports of unauthorized disclosures of PHI or suspected security incidents to DHCS within ten working days.

Category 5 – Quality Management

Category 5 includes requirements to maintain a QIS.

San Diego GMC

The Plan is required to implement and maintain a written description of its QIS that includes qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training. The written description of the Plan's QIS did not include qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to investigate fraud and abuse.

Sacramento and San Diego GMC

Fraud reports submitted to DHCS must include the source of complaint. The Plan did not include the source of complaint in fraud reports submitted to DHCS.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from November 1, 2021 through November 12, 2021. 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: 25 (12 Sacramento GMC and 13 San Diego GMC) medical prior authorization file cases were reviewed for timeliness, consistent application of criteria, and appropriate review. No medications require prior authorization under the Plan's UM program.

Appeal Procedures: Six (Three Sacramento GMC and three San Diego GMC) appeals were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 15 (Eight Sacramento GMC and seven San Diego GMC) service requests were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): Eight (Three Sacramento GMC and five San Diego GMC) medical records were reviewed to confirm coordination of care and fulfillment of HRA requirements.

California Children's Services (CCS): Six (Three Sacramento GMC and three San Diego GMC) medical records were reviewed to confirm coordination of care between the Plan and CCS providers.

Complex Case Management: Six (Three Sacramento GMC and three San Diego GMC) medical records were reviewed to confirm coordination of care.

Behavioral Health Treatment (BHT): Six (Three Sacramento GMC and three San Diego GMC) medical records were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

Claims: 20 (Ten Sacramento GMC and ten San Diego GMC) emergency service claims and 20 (Ten Sacramento GMC and ten San Diego GMC) family planning claims were reviewed for appropriate and timely adjudication.

NEMT: 40 (20 Sacramento GMC and 20 San Diego GMC) NEMT records were reviewed for appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment requirements.

NMT: 40 (20 Sacramento GMC and 20 San Diego GMC) NMT records were reviewed for appropriate adjudication. Contracted NMT providers were reviewed for Medi-Cal enrollment requirements.

Category 4 – Member's Rights

Grievance Procedures: 123 (62 Sacramento GMC and 61 San Diego GMC) grievances, including 40 quality of service, 29 quality of care, 30 exempt, and 24 expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 50 (25 Sacramento GMC and 25 San Diego GMC) Health Insurance Portability and Accountability Act /PHI breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Incidents (PQI): 12 (Six Sacramento GMC and six San Diego GMC) PQIs were reviewed for appropriate adjudication.

Provider Training: 60 (30 Sacramento GMC and 30 San Diego GMC) new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 30 (25 Sacramento GMC and five San Diego GMC) fraud and abuse cases were reviewed for processing and compliance with reporting requirements.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2019 to October 31, 2021
DATE OF AUDIT: November 1, 2021 to November 12, 2021

CATEGORY 1 - UTILIZATION MANAGEMENT

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

Sacramento GMC

1.1.1 Integration of Utilization Management (UM) into Quality Improvement System

The Plan is required to ensure that the UM program includes the integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on the review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. (*Contract, Exhibit A, Attachment 5, (1) (G)*)

The Plan's *GMC Medi-Cal Quality Oversight Committee Charter* stated that the Plan's Medi-Cal Quality Committee will conduct a quarterly review and analysis of Medi-Cal member complaints, grievances, and appeals. The charter did not mention the review of denials, deferrals, and modifications for Medi-Cal prior authorization, concurrent review, or retrospective review requests.

Finding: The Plan did not show evidence of integration of UM activities into the Plan's designated Medi-Cal QIS, including a process to integrate reports on the number and types of appeals, denials, deferrals, and modifications to the appropriate Medi-Cal quality improvement staff.

A review of the Plan's Medi-Cal Quality Committee meeting minutes from October 2019 to August 2021 revealed the committee did not review UM reports or data for denials, deferrals, and modifications of prior authorization, concurrent review, or retrospective review requests involving Medi-Cal members. In addition, the Medi-Cal quality committee did not review data or reports for Medi-Cal member appeals. There was no evidence that Medi-Cal quality staff reviewed Medi-Cal UM and appeals reports.

During the interview, the Plan stated it's UM committee reviewed UM data aggregated for members of all lines of business, which were submitted to the regional quality committee for review. Redacted meeting minutes from the regional quality committee did not show evidence that it reviewed UM reports on the number and type of denials, deferrals, modifications, and member appeals. In a written statement, the Plan acknowledged its Medi-Cal Quality Committee did not review UM reports specific to Medi-Cal members during the audit review period.

When the Plan does not integrate UM data and reports for Medi-Cal members into the Medi-Cal QIS, the Plan may miss opportunities for improvement in UM decisions and processes.

Recommendation: Develop and implement procedures to ensure Medi-Cal Quality Improvement Committees and staff review UM reports specific to Medi-Cal members, which include the number and types of denials, deferrals, and modifications as well as member appeals.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Sacramento GMC

1.2.1 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and Criteria

For members under the age of 21 years, the Plan is required to provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered services include all medically necessary services, as defined in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v). (*Contract, Exhibit A, Attachment 10, (5) (F)*)

For members under the age of 21, Plans are required to provide and cover all medically necessary EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental conditions. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable". (*APL 19-010*)

Plan policy *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)* (*revised 09/21/2020)* stated that for members under the age of 21, the Plan provides and covers all medically necessary EPSDT services, unless carved out of the Contract, regardless of whether such services are covered under the Medicaid State Plan for adults. A service is considered medically necessary if the service is necessary to correct or ameliorate defects and physical and mental conditions that are discovered by screening services.

Finding: The Plan did not provide EPSDT services when medically necessary to correct or ameliorate conditions and utilized criteria that were more restrictive than Medi-Cal EPSDT guidelines described in APL 19-010.

A verification study revealed that in two of 12 medical prior authorization requests, the Plan denied EPSDT services that were medically necessary to correct or ameliorate conditions, and decision-makers utilized criteria that were more restrictive than Medi-Cal EPSDT guidelines:

- In one case, the Plan denied a request to increase the frequency of speech therapy visits from once a week to twice a week for a pediatric member with autism and language delays. A speech therapy evaluation documented that the member was verbal and interactive soon after sessions but regressed in skills a few days after sessions despite completing home activities. The reason for the denial was the member had made good progress in language skills during weekly therapy and current medical literature did not support that more sessions would result in improved progress. The decision-maker used criteria stating that continuation of therapy is based on significant, measureable improvement in the member's condition.

- In another case, the Plan denied a request to increase the frequency of physical therapy visits from once a week to twice a week for a pediatric member with a genetic syndrome and developmental delays in motor skills. A physical therapy evaluation documented that the member had made improvements but was unable to walk or run for long durations. The reason for denial was the member had not made significant progress and current medical literature did not support that more sessions would improve progress. The decision-maker used criteria stating continuation of therapy is based on significant, measureable improvement in the member's condition. The Plan stated the member's physical therapy services would end once the current authorization period expired.

For both cases, the Plan's criteria and decision conflicted with APL 19-010, which stated EPSDT coverage includes services that sustain, support, or prevent a condition from worsening rather than those that cure or improve health problems.

The Plan's 2021 UM criteria for occupational therapy and physical therapy did not describe Medi-Cal EPSDT guidelines in detail, such as a description of maintenance services and services that ameliorate a condition, and listed an outdated APL in the body of the criteria. The Plan's 2021 UM Criteria for speech therapy did not mention or describe Medi-Cal EPSDT requirements, such as a description of maintenance services and services that ameliorate a condition, and did not list APL19-010 in the body of the criteria.

During the interview, the Plan stated it informed decision-makers of Medi-Cal EPSDT guidelines through staff meetings.

When the Plan uses criteria that are more restrictive than Medi-Cal EPSDT guidelines, members under the age of 21 may not receive medically necessary services which may affect members' conditions.

Recommendation: Revise and implement UM criteria and procedures to ensure Medi-Cal EPSDT guidelines described in APL 19-010 are used for decision-making and to provide medically necessary services to correct or ameliorate conditions.

San Diego GMC

1.2.1 Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) and Criteria

For members under the age of 21 years, the Plan is required to provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered services include all medically necessary services, as defined in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v). (*Contract, Exhibit A, Attachment 10, (5) (F)*)

For members under the age of 21, Plans are required to provide and cover all medically necessary EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental conditions. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable". (*APL 19-010*)

Plan policy *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services and Behavioral Health Treatment (BHT) Coverage for Medi-Cal Members Under 21* (*effective 08/01/2018*) stated that the Plan provides speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services are covered under the state plan.

Plan policy *SC.HPHO.050 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)* (*effective 03/15/2021*) stated that the Plan provides and covers all medically necessary EPSDT services, unless otherwise carved-out of the Contract. A service is considered medically necessary if the services is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.

Finding: The Plan did not provide EPSDT services when medically necessary to correct or ameliorate conditions and utilized criteria that were more restrictive than Medi-Cal EPSDT guidelines described in APL19-010.

A verification study revealed that in six of 13 medical prior authorization requests, the Plan limited speech therapy services that were medically necessary to correct or ameliorate conditions, and decision-makers utilized criteria that were more restrictive than Medi-Cal EPSDT guidelines:

- In one case, the Plan denied a request for six months of speech therapy and instead approved three months. The pediatric member had autism and language/speech disorders, and a speech therapy evaluation documented continued delays in language skills necessary to participate in activities of daily living, such as an inability to verbalize needs to others or organize a cohesive narrative. The reason for the decision was the member's skills were not improving. The decision-maker used criteria stating services will be discontinued when there has been failure to progress in treatment.

- In another case, the Plan denied a request for six months of speech therapy and instead approved three months with a plan to monitor the member for discharge from speech therapy. The pediatric member had autism and language/speech disorder, and a speech therapy evaluation documented that the member had difficulty producing grammatical sentences and age-appropriate speech sounds. The reason for the decision was the member made no significant progress in language development and no improvement in assessment scores. The decision-maker used criteria stating services will be discontinued when there has been failure to progress in treatment.

- In another case, the Plan denied a request for six months of speech therapy and instead approved one month with a plan to end services after the current authorization period expired. The pediatric member had behavioral issues and severe language delays requiring the use of an assistive communication device. A speech therapy evaluation documented that the member made progress on the ability to make requests and follow simple directions but would still benefit from further therapy to increase functional communication skills such as communicating new phrases and requesting things. The reason for the decision was the member did not show functional improvements in language skill level and made no significant progress in assessment scores. The decision-maker used criteria stating services will be discontinued when there has been failure to progress in treatment.

- In another case, the Plan denied a request for 26 weeks of speech therapy and instead approved eight weeks with a plan to end services after the current authorization period expired. The pediatric member had autism and a language disorder, and a speech therapy evaluation documented continued issues with using language skills with peers as well as a lisp. The reason for the decision was the member was at an age-appropriate functional level for language skills based on recent assessment scores. The decision-maker used criteria stating that services will be discontinued when the member has reached an age-appropriate functional level.

- In another case, the Plan denied a request for speech therapy three times a week and instead approved services twice a week. The pediatric member had an intellectual disability and a language/speech disorder, and a speech therapy evaluation documented that the member made improvements in speech but continued to show poor comprehension. To ensure the member did not regress between sessions, the speech therapist recommended an increase in frequency from twice a week to three times a week. The reason for denial was the member did not show functional improvements in language skill level or assessment scores. The decision-maker used criteria stating services will be discontinued when there has been failure to progress in treatment.

- In another case, the Plan denied a request for six months of speech therapy and instead approved one month with a plan to end services after the current authorization period expired. The pediatric member had autism and a language/speech disorder. A speech therapy evaluation documented the member's struggle to produce the "r" sound and the need for continued therapy to increase the ability to be understood by others. The reason for the decision was the member's language skills were found to be age-appropriate based on assessment scores. The decision-maker used criteria stating services will be discontinued when the member has reached an age-appropriate functional level.

For all six cases, the Plan's criteria and decision conflicted with APL 19-010, which stated EPSDT coverage includes services that sustain, support, or prevent a condition from worsening rather than those that cure or improve health problems.

The Plan's 2021 UM Criteria for speech therapy, occupational therapy, and physical therapy did not describe current Medi-Cal EPSDT guidelines in detail, such as a description of maintenance services and services that ameliorate a condition, and listed an outdated APL in the body of the criteria.

During the interview, the Plan acknowledged it's UM criteria for speech, occupational, and physical therapy contained links to an outdated APL on EPSDT. The Plan stated it informed decision-makers of Medi-Cal EPSDT guidelines through staff trainings.

Recommendation: Revise and implement UM criteria and procedures to ensure Medi-Cal EPSDT guidelines described in APL 19-010 are used for decision-making and to provide medically necessary services to correct or ameliorate conditions.

San Diego GMC

1.2.2 Translation of Notice of Action (NOA) Letter Packet into Threshold Language

The Plan is required to provide, at a minimum, fully translated member information, including but not limited to the member services guide, welcome packets, marketing information and form letters including NOA letters and grievance and appeal acknowledgement and resolution letters. The Plan is required to provide translated written informing materials to all monolingual or limited English-proficient members that speak the identified threshold or concentration standard languages. (*Contract, Exhibit A, Attachment 9, (14) (C)*)

Plans are required to provide translated written member information to the following population groups within the Plan's service areas who indicate their primary language as a language other than English: a population group who meets the definition of threshold standard language and a population group who meets the definition of concentration standard language. Member information includes documents that are vital or critical to obtaining services and/or benefits and includes NOA letters and any notices related to grievances, actions, and appeals. (*APL 21-004*)

Plan Policy *SC.RUM.016 Utilization Management Denial of Practitioner Requested Services* (*revised 06/03/2021*) stated that denial notices must include a statement offering to provide denial notices in the member's preferred language as required by state and federal regulations.

Plan Policy *CA.HP.Operations.LA 005001 Quality Translation Process for Member Informing Materials* (*revised 11/01/2020*) listed threshold languages by county and stated that the Plan must produce and distribute vital documents to members in their preferred Medi-Cal threshold language. The Plan must include the notice of nondiscrimination in the corresponding threshold language. Vital documents were defined as written materials that are essential for understanding health plan benefits or accessing covered services including denial letters.

Finding: The Plan did not translate member information in a NOA letter packet into the required threshold and/or concentration language.

A verification study revealed that in one of two medical prior authorization requests requiring translation, the Plan did not mail a translated NOA letter packet to the member in the required threshold language. The demographic information sheet indicated the member's preferred written language was Spanish and preferred spoken language was English. The mailed NOA letter, Your Rights attachment, and nondiscrimination notice were not translated.

In a written statement, the Plan described that its system automatically selected the translation language based on the member's preferred spoken language field. The Plan stated it would correct its system to select translation languages based on the member's preferred written language field.

When the Plan does not translate member information in NOA letter packets into threshold languages, members may not fully understand the Plan's decisions and rationale regarding their health care and may not be able to exercise their rights for appeals, grievances, state fair hearings, and independent medical review.

Recommendation: Revise and implement policies and procedures to ensure that member information in NOA letter packets are fully translated into required threshold and concentration languages.

Sacramento GMC

1.2.3 Reference to Criteria in Notice of Action (NOA) Letters

The Plan is required to comply with all existing final policy letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2, (1) (D)*)

For decisions based in whole or in part on medical necessity, the written NOA must contain a description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decisions, as well as an explanation of the criteria or guideline. (*APL 17-006; Superseded by APL 21-011*)

Plan Policy *17.0 Utilization Management Denial of Practitioner Requested Services* (*revised 02/23/2021*) stated that for denial notices, the denial rationale should include reference to the specific criteria upon which the decision was made.

Finding: The Plan did not include a reference to the specific criteria or guidelines used to support medical necessity decisions within NOA letters.

A verification study revealed that in two of 12 medical prior authorization service requests, the Plan did not specify the name of criteria or guidelines used to make the decision in NOA letters:

- In a medical necessity denial of a wheelchair, the physician reviewer used criteria language derived from the Plan's Durable Medical Equipment criteria and the Member Handbook. However, the NOA letter did not name these criteria sources.

- In a medical necessity denial of aquatic therapy, the physician reviewer used criteria language derived from the Member Handbook stating aquatic therapy is only a covered benefit when it is part of a physical therapy treatment plan. The NOA letter stated the "Services you cannot get through Kaiser Permanente or Medi-Cal section" was used to make the decision. However, the NOA letter did not specify that the section was derived from the Member Handbook.

During the interview, the Plan stated a UM nurse selects appropriate clinical criteria for cases and submits them to the physician reviewer. After the physician reviewer makes a denial or modification decision, the UM nurse drafts the NOA letter and inserts the applicable criteria information into the NOA letter for all denials involving medical necessity.

When the Plan does not reference specific criteria or guidelines used to make the decision, the basis for denials is unclear. Members and providers may not be fully informed about decisions that impact their healthcare and may not have adequate information to appeal the decisions.

Recommendation: Implement policies and procedures to ensure that the Plan references specific criteria and guidelines used for medical necessity denials and modifications in NOA letters.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT

Sacramento GMC

2.1.1 Private Duty Nursing (PDN) Notice to Members

The Plan is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must explain that the Plan has primary responsibility for case management of PDN services, describe the case management services available to the member in connection with PDN services and explain how to access those services. The notice must include a statement that a member may utilize the Plan's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services, file a Medi-Cal fair hearing as provided by law or email DHCS directly, and include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California. Plans are required to issue new or revised policies and procedures that comply with the requirements of this APL. (*APL 20-012*)

Plan policy *Private Duty Nursing Case Management Responsibilities for Medi-Cal Members under the Age of 21* (*effective 08/15/2020*) stated that the Plan will provide information including, but not limited to, the number of approved PDN hours to EPSDT eligible Medi-Cal members.

Finding: The Plan did not issue notice to members under the age of 21 for whom it has authorized PDN services in accordance with APL 20-012.

In a written statement, the Plan stated that notice to members notifying them of authorized PDN hours, etc., is "verbal" and notification to members are documented in the medical record. The Plan stated its PDN Committee will review the APL 20-012 requirements and "will adopt the formal written notice requirements."

When the Plan does not notify members of PDN services, members may not be able to understand the PDN benefits or exercise their rights to grievances, appeals, fair hearings, and other assistance for PDN services.

Recommendation: Revise and implement policies and procedures to notify members with authorized PDN services in accordance with APL 20-012.

San Diego GMC

2.1.1 Private Duty Nursing (PDN) Notice to Members

The Plan is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must explain that the Plan has primary responsibility for case management of PDN services, describe the case management services available to the member in connection with PDN services and explain how to access those services. The notice must include a statement that a member may utilize the Plan's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services, file a Medi-Cal fair hearing as provided by law or email DHCS directly, and include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California. Plans are required to issue new or revised policies and procedures that comply with the requirements of this APL. (*APL 20-012*)

Plan policy *Supplemental Shift Care Nursing Services as an Early Periodic Screening and Diagnosis and Treatment (EPSDT) Benefit* (*revised 09/29/2020*) stated that approvals for care are communicated to the member and referring physician by the Home Health Agency. Case management responsibilities as outlined by APL 20-012 are to provide the member with information about the number of PDN hours the member is approved to receive.

Finding: The Plan did not issue notice to members under the age of 21 for whom it has authorized PDN services in accordance with APL 20-012.

In an interview, the Plan stated it determines the number of shift care hours and submits the approval to the appropriate home health agency. The Plan acknowledged it does not provide the PDN notification to the member or receive a copy of the PDN notification letter from the home health agency. Although the Plan explained that the home health agency only sends written notice to members upon request, the Plan did not provide any documentation to show that the process is implemented as described in the APL.

When the Plan does not notify members of PDN services, members may not be able to understand the PDN benefits or exercise their rights to grievances, appeals, fair hearings, and other assistance for PDN services.

Recommendation: Revise and implement policies and procedures to notify members with authorized PDN services in accordance with APL 20-012.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.6	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Sacramento and San Diego GMC

3.6.1 Family Planning Claim Denials

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan is required to provide an accurate and clear written explanation of the specific reasons. *(California Code of Regulations, Title 28, Section 1300.71 (d) (1) and (h))*

Plan policy *POL-005 Payments to Providers (updated 09/14/20)* stated that claims submitted with an incorrect or missing National Drug Code (NDC) would be denied.

Plan policy *National Claims Administration Medi-Cal Management Guide (revised 06/21/21)* stated that the Plan's claim processing system would deny claims submitted without appropriate NDC information.

Finding: The Plan improperly denied family planning services based on other services submitted on the claim.

A verification study of ten Sacramento GMC and ten San Diego GMC family planning service claims revealed the following:

- The Plan incorrectly denied three of ten Sacramento GMC family planning service claims because the claim did not contain the NDC for a drug code billed. All three claims contained two claim lines, one for a family planning office visit and one for an accompanying drug code. The Plan denied all three entire claims for missing the NDC; the providers billed for an office visit (service code 99213), which did not require a NDC.

- The Plan incorrectly denied one of ten San Diego GMC family planning service claims because the claim did not contain the NDC for a drug code. The Plan denied the entire claim for missing the NDC; the provider correctly billed for removal of intrauterine device (service code 58301), which did not require a NDC.

During the interview, the Plan stated its current process would deny the entire claim if a NDC was missing.

If the Plan improperly denies covered services, providers may be discouraged from treating Plan members; members' access to care may be limited.

Recommendation: Revise and implement procedures to ensure claims are appropriately adjudicated.

San Diego GMC

3.6.2 Family Planning Payments

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract, Exhibit E, (2) (1) (D))*

The Plan is required to directly pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013, using Proposition 56 appropriated funds. This payment obligation applies to contracted and non-contracted providers. The uniform dollar add-on amounts for the services listed are in addition to whatever other payments eligible providers would normally receive from the Plan. For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the Plan receives payment from DHCS, the Plan must ensure that payments required by this APL are made within 90 calendar days. From the date the Plan receives payment onward, the Plan must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim. *(APL 20-013)*

Plan policy *POL-005 Payments to Providers (updated 09/14/20)* stated that claims adjudication complies with the rules of governing/regulatory bodies such as state and federal law and other requirements, which may be applicable.

Finding: The Plan did not distribute timely add-on payments for specified family planning claims in accordance with APL 20-013.

A verification study found in one of ten family planning claims, the Plan did not distribute add-on payments in accordance with APL 20-013. This claim was received by the Plan on August 26, 2020.

In a written response, the Plan stated it has a process in which no add-on family planning payments will be issued unless the vendor name and Taxpayer Identification Number (TIN) have been validated. The provider in this sample was not in the vendor population for the initial and only validation. The add-on payment to this provider was made after DHCS' audit request, which was after the 90 calendar day timeframe. The Plan stated going forward it plans to implement a monthly vendor name and TIN validation for new providers.

When the Plan does not distribute payments within the required timeframe, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Develop and implement procedures to distribute timely add-on payments for specified family planning claims in accordance with APL 20-013.

3.8	NON-MEDICAL TRANSPORTATION AND NON-EMERGENCY MEDICAL TRANSPORTATION

Sacramento and San Diego GMC

3.8.1 Non Medical Transportation (NMT) Provider Enrollment Verification

Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all Plan network providers, aligning with the Fee-For-Service (FFS) enrollment requirements. These requirements apply to both existing contracting network providers as well as prospective network providers. Plans may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process. (*APL 19-004*)

Plans may execute network provider agreements pending the outcome of the provider's enrollment up to 120 days, but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees. *(42 CFR, Section 438.602(b) (2))*

Plan policies Sacramento GMC *Provider Screening and Enrollment* (*effective 01/01/2018*) and San Diego GMC *SC.HPHO.048 Provider Screening and Enrollment* (*effective 02/24/2021*) stated that the Plan will allow providers to participate in its network for up to 120 days, pending the outcome of the DHCS screening process.

Finding: The Plan did not verify the outcome of NMT providers' enrollment after 120 days from the effective dates of the provider agreements. The Plan did not terminate the un-enrolled NMT providers after 120 days.

A verification study of seven NMT providers showed that the Plan and its subcontractor did not track the outcome of the enrollment applications once the provider agreements were signed. The subcontractor's NMT roster showed that six providers submitted DHCS enrollment applications with submitted dates ranging from June 2018 to November 2019, while another provider submitted an application in June 2006. As of September 2021, these providers still had a pending status on their DHCS enrollment applications.

In an interview, the Plan stated it had no time limit for a provider to remain in pending status.

In written statements, the Plan stated that three of seven NMT providers were in the process of resubmitting the enrollment applications in 2021. Two providers already resubmitted enrollment applications in 2021. The remaining two providers were subsequently confirmed as enrolled with DHCS. However, for all seven providers the Plan verified enrollment status after DHCS' audit request, which was after the 120-day period.

When the Plan does not verify the outcome of enrollment status for all NMT providers, members may receive substandard services from unenrolled providers.

Recommendation: Implement Plan's policies and develop procedures to verify the outcome of NMT providers' enrollment after 120 days from the effective dates of the provider agreements.

San Diego GMC

3.8.2 Non-Emergency Medical Transportation (NEMT) Provider Enrollment Verification

Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, aligning with the FFS enrollment requirements. These requirements apply to both existing contracting network providers as well as prospective network providers. (*APL 19-004*)

Managed Care Plans may execute network provider agreements pending the outcome of the provider's enrollment up to 120 days, but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees. *(42 CFR Section 438.602(b) (2))*

Plan policy *SC.HPHO.048 Provider Screening and Enrollment (effective 02/24/21)* stated that Plan will allow providers to participate in its network for up to 120 days, pending the outcome of the DHCS screening process.

Finding: The Plan did not verify NEMT providers' enrollment status after 120 days from the effective dates of the provider agreements.

A verification study of four NEMT providers showed that three providers had not applied with DHCS when the provider agreements were signed. Another provider had pending status on its DHCS enrollment application when the provider agreement was signed. The effective dates of the provider agreements for all four NEMT providers range from May 2018 to April 2019. The Plan did not track these providers' enrollment status after the 120-day period from the provider agreement dates.

In written requests to verify enrollment of these NEMT providers by DHCS, the Plan indicated that three providers submitted the enrollment applications in 2021. The remaining provider was confirmed as enrolled with Medi-Cal. However, for all four providers the Plan verified enrollment status after DHCS' audit request, which was after the 120-day period.

When the Plan does not verify the outcome of enrollment status for all NEMT providers, members may receive substandard services from unenrolled providers.

Recommendation: Implement Plan's policies and develop procedures to verify the outcome of NEMT providers' enrollment status after 120 days from the effective dates of the provider agreements.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Sacramento and San Diego GMC

4.1.1 Standard Grievance Acknowledgement

The Plan is required to follow grievance and appeal requirements, and use all notice templates included in APL 17-006. The Plan is required to ensure timely acknowledgement for each grievance. (*Contract, Exhibit A, Attachment 14, (B)*)

The Plan is required to provide written acknowledgement to the member that is dated within five calendar days of receipt of a standard grievance *(APL 17-006 and 21-011)*.

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (effective 11/18/2019)* stated that all grievances will be acknowledged within five calendar days.

Finding: The Plan did not provide members with written acknowledgment within five calendar days of receipt of a standard grievance.

A verification study of 35 Sacramento GMC and 34 San Diego GMC standard grievances revealed the following:

- Three of 35 Sacramento GMC standard grievances had late written acknowledgment letters. The delayed timeframes ranged from six to 45 calendar days from the grievance receipt date.

- Four of 34 San Diego GMC standard grievances had late written acknowledgment letters. The delayed timeframes ranged from seven to 36 calendar days from the grievance receipt date.

In a written response, the Plan stated that staff errors and delay of case handoff between teams resulted in the late acknowledgement letters.

Delayed acknowledgement of member grievances may result in missed opportunities for members to participate in the Plan's grievance process.

Recommendation: Implement policies and procedures to provide written grievance acknowledgment letters to members within five calendar days.

Sacramento and San Diego GMC

4.1.2 Standard Grievance Resolution

The Plan is required to follow grievance and appeal requirements, and use all notice templates included in APL 17-006. The Plan is required to provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 calendar days from the receipt date of the standard grievance*. (Contract, Exhibit A, Attachment 14, (1) (B))*

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of a standard grievance. Federal regulations allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to grievances. *(APL 17-006 and 21-011)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (effective 11/18/2019)* stated that all standard grievances will be resolved within 30 calendar days. Extension of standard grievance timeframe is not allowed.

Finding: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the standard grievance.

A verification study of 35 Sacramento GMC and 34 San Diego GMC standard grievances revealed the following:

- Four of 35 Sacramento GMC standard grievances had late resolution letters that ranged from 42 to 106 calendar days.

- Five of 34 San Diego GMC standard grievances had late resolution letters that ranged from 32 to 147 calendar days.

In a written response, the Plan stated that staff error, late responses to investigation inquiries or delays in case handoff between teams resulted in late resolution letters.

Delayed member notifications of grievance resolutions may result in missed opportunities for improved health care delivery and poor health outcomes for members.

Recommendation: Implement policies and procedures to ensure the Plan provides written resolution to members within 30 calendar days from the date of receipt of grievances.

Sacramento and San Diego GMC

4.1.3 Expedited Grievance Resolution

The Plan is required to provide oral notice of the resolution of an expedited review within 72 hours. *(Contract, Exhibit A, Attachment 14, (H))*

The Plan is required to provide resolution of expedited grievances to the member within 72 hours of receipt of the grievance *(APL 17-006 and 21-011)*.

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (effective 11/18/2019)* stated that, for expedited grievances, resolution must be provided with 72 hours from the receipt time.

Finding: The Plan did not provide oral resolution to the member within the required 72-hour timeframe for expedited grievances.

A verification study of 12 Sacramento GMC and 12 San Diego GMC expedited grievances showed the following:

- Five of 12 Sacramento GMC expedited grievances had late oral resolution notices that ranged from 100 to 113 hours from the receipt time.

- Four of 12 San Diego GMC expedited grievances had late oral resolution notices that ranged from 102 to 337 hours from the receipt time.

In a written response, the Plan stated that staff errors and delays in case handoff between teams resulted in late oral resolutions.

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

Recommendation: Implement policy and procedures to provide expedited grievance oral resolution within 72 hours of receipt.

San Diego GMC

4.1.4 Written Notification of Grievance Resolution Delays

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. However, in the event that resolution of a standard grievance is not reached within 30 calendar days as required, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution, which should not exceed 14 calendar days. *(APL 17-006 and 21-011)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (effective 11/18/2019)* stated that extensions are not allowed for grievances.

Finding: The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days.

A verification study revealed that in two of five late standard grievances, the Plan did not send written notices of delayed resolution to members.

In a written response, the Plan stated that staff errors resulted in delay notifications not being sent to the members.

When the Plan does not send written notification of delay for grievances, members may not be aware of resolution status which may result in poor health outcomes.

Recommendation: Develop and implement procedures to ensure that members are notified in writing of grievance resolution delays.

Sacramento GMC

4.1.5 Grievance Resolution Criteria

The Plan is required to have in place a system in accordance with 28 CCR 1300.68. (*Contract, Exhibit A, Attachment 14, (1)*)

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

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (*revised 07/23/2021*) defined initial determinations as grievances in which the member makes an initial request for a service or referral. The policy stated that a decision rationale for all denials, delays, or modifications of healthcare services shall include the clinical reasons for medical necessity denial, identification of any criterion or guideline used as the basis for the decision, and a clear and concise clinical explanation as to why the member does not meet the criterion or guideline.

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

A verification study showed deficiencies in citing criteria, clinical guidelines and medical policies for the Plan's denial decisions in three of 15 standard quality of care grievances and in two of 12 expedited grievances:

- In one case, the Plan denied stimulant medication for a member stating it was not medically indicated. The decision-maker's rationale stated "Decisions regarding specific medications…are made by the treating physicians based on their clinical evaluation. We rely on the judgement of the treating physicians." Clinical criteria, guidelines, or policies were not cited in the decision-maker's rationale or grievance resolution letter.

- In another case, the Plan denied out-of-Plan mental health services for a pediatric member with depression where the family preferred in-person appointments with culturally appropriate providers because the current psychiatric treatment plan was not effective. The decision-maker determined that out-of-Plan care was not medically indicated and appropriate care was available within the Plan based on expert opinion and review of the clinical records. The rationale and grievance resolution letter did not cite relevant policies, guidelines, or criteria that describe when out-of-Plan care would be indicated.

- In another case, the Plan denied opioid and benzodiazepine medication refills for a member with chronic pain undergoing an opioid tapering program. Based on clinical record review, the decision-maker determined the medications were not medically indicated and would increase the chance of adverse outcomes. The rationale and grievance resolution letter did not cite relevant policies, guidelines, and criteria for opioid and benzodiazepine medications.

- In one expedited case, the Plan denied a referral to an orthopedic specialist and a kidney evaluation for a member with chronic back pain. Regarding the back pain, the decision-maker noted there were no concerning symptoms and the member should follow up with their Primary Care Provider (PCP). For the kidney evaluation, the decision-maker stated the member should follow up with the PCP for a preliminary evaluation. The rationale and grievance resolution letter did not cite applicable policies, guidelines, and criteria.

- In another expedited case, the Plan denied a request for pain medication in a member with abdominal pain. The decision-maker stated that pain medication could not be administered without evaluation by the PCP to determine the cause of the abdominal pain. The rationale and grievance resolution letter did not cite applicable medical policies, guidelines, and criteria.

During interviews, the Plan stated that physician decision-makers selected applicable clinical criteria when available. Non-clinical case processors input the decision-maker's decision and criteria into the grievance resolution letters. The Plan stated when criteria may not be applicable, the determination was based on clinical expertise of decision-makers and reviewers. A clinical criteria set from a vendor became available for use in March 2020; however, the Plan stated it did not enforce utilization of the criteria set during the audit period.

In response to the prior audit finding 4.1.2, the Plan trained its case processors in March 2020 to ensure criteria were included as part of the decision-maker's review and to insert applicable criteria into the grievance resolution letter. However, the verification study demonstrated the deficiency was not corrected.

When the Plan does not cite criteria for decisions to deny clinical services that are not medically indicated, the basis for denials is unclear. Members may not be fully informed about decisions that impact their health care and may not have adequate information to appeal the decisions.

This is a repeat of prior audit finding 4.1.2 Grievance Resolution Criteria.

Recommendation: Implement policies and develop processes to clearly state the criteria, clinical guidelines, and medical policies utilized for medical necessity decisions of clinical services requested through the grievance process.

San Diego GMC

4.1.5 Grievance Resolution Criteria

The Plan is required to have in place a system in accordance with 28 CCR 1300.68. (*Contract, Exhibit A, Attachment 14, (1)*)

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

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (*revised 07/23/2021*) defined initial determinations as grievances in which the member makes an initial request for a service or referral. The policy stated that a decision rationale for all denials, delays, or modifications of healthcare services shall include the clinical reasons for medical necessity denial, identification of any criterion or guideline used as the basis for the decision, and a clear and concise clinical explanation as to why the member does not meet the criterion or guideline.

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

A verification study showed deficiencies in citing criteria, clinical guidelines and medical policies for the Plan's denial decisions in three of 14 standard quality of care grievances and in two of 12 expedited grievances:

- In one case, the Plan denied opioid medication and a third opinion for pain management for a member with chronic bladder pain. The decision-maker recommended a multidisciplinary approach using non-opioid treatment options and stated "I don't see any reason for a third opinion". The decision-maker's rationale and grievance resolution letter did not cite established criteria, guidelines, or medical policies for pain management.

- In another case, the Plan denied an autism assessment for a pediatric member with behavioral issues. The decision-maker stated the member needed an initial mental health evaluation in the Psychiatry department in order to determine if an autism assessment was indicated. The decision-maker's rationale and grievance resolution letter did not cite medical policies or workflow procedures for autism assessments.

- In another case, the Plan denied urgent colonoscopy and surgical intervention to a member with a complex abdominal and bladder issue. The decision-maker stated the decision was based on medical record review and expert opinion. The decision-maker's rationale and grievance resolution letter did not cite applicable criteria, guidelines, or medical policies.

- In one expedited case, the Plan denied the member's request for imaging of the knee, an earlier neurology appointment, and preventive medications for migraines. The decision-maker stated the member needed to see the orthopedic provider to determine if imaging was indicated. The decision-maker denied an earlier neurology appointment and medications for migraines because the member was clinically stable and required a neurologist evaluation to determine the treatment plan. The decision-maker's rationale and grievance resolution letter did not cite applicable criteria, guidelines, or medical policies.

- In another expedited case, the Plan denied the member's request for shoulder surgery for a shoulder injury. As the rationale, the decision-maker cited a specific clinical criteria set from a vendor that required several weeks of conservative treatment before consideration of surgery. However, the resolution letter did not cite the clinical criteria used by the decision-maker.

During interviews, the Plan stated that physician decision-makers selected applicable clinical criteria when available. Non-clinical case processors input the decision-maker's decision and criteria into the grievance resolution letters. The Plan stated when criteria may not be applicable, the determination was based on clinical expertise of decision-makers and reviewers. A clinical criteria set from a vendor became available for use in March 2020; however, the Plan stated it did not enforce utilization of the criteria set during the audit period.

When the Plan does not cite criteria for decisions to deny clinical services that are not medically indicated, the basis for denials is unclear. Members may not be fully informed about decisions that impact their health care and may not have adequate information to appeal the decisions.

Recommendation: Implement policies and develop processes to clearly state the criteria, clinical guidelines, and medical policies utilized for medical necessity decisions of clinical services requested through the grievance process.

Sacramento GMC

4.1.6 Decisions for Grievances with Clinical Issues

The Plan is required to ensure that the person making the final decision for the proposed resolution has clinical expertise in treating a member's condition or disease if deciding on any grievance or appeal involving clinical issues. (*Contract, Exhibit A, Attachment 14, (1) (D)*)

Plan Policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (*revised 07/23/2021)* stated that at least one licensed practitioner practicing in the same or similar specialty that typically manages the relevant medical condition, procedure, or treatment must review cases involving medical necessity and/or clinical issues. Decision-making for medical necessity requests and requests involving a disputed health care service that is a covered benefit require licensed physician review for final determination.

Finding: A person with clinical expertise in treating a member's condition did not make the final resolution decision for a grievance with clinical issues.

A verification study revealed that in one of 14 standard quality of care grievances, a reviewer with clinical expertise in treating a member's condition did not make the final decision.

In this grievance case, the member complained of back pain and the medication prescribed by her doctor was not improving the pain. The case processor sent a grievance investigation inquiry to a physician; however, the physician's response to the grievance was never received. Therefore, a person with clinical expertise in treating the member's back pain, such as a physician, did not review and resolve the member's complaint about back pain treatment before the case processor closed the grievance in June 2020.

During the interview, the Plan described its grievance process. Case processors determined which reviewers should receive investigation inquiries. For grievances involving physician issues and medical necessity requests, the investigation inquiries were sent to physician reviewers. For non-physician-related issues, the investigation inquiries were sent to appropriate reviewers such as nurse managers, behavioral health professionals, or department managers. Case processors requested responses from reviewers in order to resolve the grievance. If a reviewer did not respond to an investigation inquiry, the case processor would resend the inquiry through the case tracking system. Case processors could also escalate missing responses through assistance from administrators.

Prior to March 2020, the Plan did not always submit investigation inquiries or require responses from reviewers for all grievances. The Plan began sending investigation inquiries to appropriate reviewers for all standard grievances on March 15, 2020. In addition, case processors were trained in March 2020 to obtain responses to investigation inquiries prior to closing Medi-Cal grievances. However, the verification study demonstrated the Plan did not ensure the physician reviewer responded to the investigation inquiry regarding a medical complaint in a case received after the March 2020 training.

After the Exit Conference, the Plan submitted documents for the grievance sample showing a nursing manager appropriately investigated and resolved the member's claim of poor nursing care. However, the Plan did not submit evidence that a physician investigated or resolved the member's medical complaint of continued back pain after taking a medication prescribed by a physician.

When the Plan does not ensure that a person with clinical expertise in treating a member's condition makes the final decision for grievances with clinical issues, the resolution may not be clinically appropriate and may adversely impact a member's health care.

Recommendation: Revise and implement procedures to ensure documentation that a person with clinical expertise in treating a member's condition makes the final resolution decision for grievances with clinical issues.

San Diego GMC

4.1.6 Decisions for Grievances with Clinical Issues

The Plan is required to ensure that the person making the final decision for the proposed resolution has clinical expertise in treating a member's condition or disease if deciding on any grievance or appeal involving clinical issues. (*Contract, Exhibit A, Attachment 14, (1) (D)*)

Plan Policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (*revised 07/23/2021)* stated that at least one licensed practitioner practicing in the same or similar specialty that typically manages the relevant medical condition, procedure, or treatment must review cases involving medical necessity and/or clinical issues. Decision-making for medical necessity requests and requests involving a disputed health care service that is a covered benefit require licensed physician review for final determination.

Finding: A person with clinical expertise in treating a member's condition did not make the final resolution decision for grievances with clinical issues.

A verification study revealed that in two of 14 standard quality of care grievances and in one of 20 standard quality of service grievances, a reviewer with clinical expertise in treating a member's condition did not make the final decision:

- In one quality of care grievance, the member complained that imaging results from an outside facility were submitted to the Plan but were lost, which led to delays in receiving care from an urologist. In addition, the member was concerned that imaging done previously by the Plan may have missed an ovarian cyst and was worried about radiation exposure from further imaging. The case processor sent an investigation inquiry to two physician reviewers. However, no responses were received from the physicians because the case processor did not request a response. The grievance was closed in August 2020 without documentation of the physicians' investigation and resolution.

- In another quality of care grievance, the member claimed of suffering lacerations and nerve damage in the mouth after an accident occurred during pulmonary function testing. An investigation inquiry was sent to a nurse department manager who determined the member's claims could not be substantiated and appropriate care was provided by the respiratory therapist. The Plan stated the case processor did not send an investigation inquiry to a physician because the grievance involved a quality of service issue involving a non-clinician. The grievance was closed in March 2021 without resolution by a decision-maker who was qualified to treat the member's clinical complaints of damage to the mouth.

- In a quality of service grievance, the member complained about the quality of care received from a physician provider. The member claimed medications prescribed by the physician were causing side-effects and the member's leg pain was worsening. The grievance resolution letter stated an inquiry was sent to a physician. However, the case file did not show evidence of an investigation inquiry or that the case processor sent an investigation inquiry to a physician. A physician's response regarding the clinical complaints was not received, and the case processor closed the case in January 2021. The Plan stated the lack of documentation likely resulted from staff error.

During the interview, the Plan described its grievance process. Case processors determined which reviewers should receive investigation inquiries. For grievances involving physician issues and medical necessity requests, the investigation inquiries were sent to physician reviewers. For non-physician-related issues, the investigation inquiries were sent to appropriate reviewers such as nurse managers, behavioral health professionals, or department managers. Case processors requested responses from reviewers in order to resolve the grievance. If a reviewer did not respond to an investigation inquiry, the case processor would resend the inquiry through the case tracking system. Case processors could also escalate missing responses through assistance from administrators.

Prior to March 2020, the Plan did not always submit investigation inquiries or require responses from reviewers for all grievances. The Plan began sending investigation inquiries to appropriate reviewers for all standard grievances on March 15, 2020. In addition, case processors were trained in March 2020 to obtain responses to investigation inquiries prior to closing Medi-Cal grievances. However, the verification study demonstrated the Plan did not ensure that physician reviewers responded to investigation inquiries regarding medical complaints; all cases reviewed in the verification study were received by the Plan after the March 2020 training.

When the Plan does not ensure that a person with clinical expertise in treating a member's condition makes the final decision for grievances with clinical issues, the resolution may not be clinically appropriate and may adversely impact a member's health care.

Recommendation: Revise and implement procedures to ensure documentation that a person with clinical expertise in treating a member's condition makes the final resolution decision for grievances with clinical issues.

4.3	CONFIDENTIALITY RIGHTS

San Diego GMC

4.3.1 Complete Investigation Reporting of Incidents and Disclosures

The Plan is required to provide a complete investigation report to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten working days 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. (*Contract, Exhibit G, Attachment 3, (J)*)

Plan policy *SC.RCO.PS.025: Notifications Regarding Breaches of PHI (revised 06/18/19)* stated that the Plan shall "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 working days of the discovery of the breach or unauthorized use or disclosure."

Finding: The Plan did not submit complete investigation reports of impermissible disclosures of PHI or suspected security incidents to DHCS within ten working days.

A verification study revealed four cases where, in lieu of providing a complete investigation report to DHCS, the Plan requested to withdraw the cases when its investigation discovered no Medi-Cal member was affected or no breach had occurred.

In an interview, the Plan stated its investigations determined no breach had occurred/affected Medi-Cal members, so the Plan would request to withdraw all investigation reports related to the case. In a written statement, the Plan stated that by withdrawing, it is excluding that report from the count of Plan incidents and breaches. However, the contract requires submission of complete investigation reports; it does not allow any exceptions.

When the Plan does not provide complete investigation reports, DHCS is unable to review and make the determination whether a breach had occurred/affected Medi-Cal members.

Recommendation: Implement policies and procedures to ensure that all complete investigation reports of unauthorized disclosures of PHI or suspected security incidents are provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten working days.

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

San Diego GMC

5.1.1 Quality Program Description

The Plan is required to implement and maintain a written description of its Quality Improvement System (QIS) that includes qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training. (*Contract, Exhibit A, Attachment 4, (7) (C)*)

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

The Plan's regional quality department staff managed quality activities and the regional quality committee provided quality oversight for all lines of business for Southern California. The Plan designated two Medi-Cal quality committees to provide oversight to the Medi-Cal line of business, one of which was the Medi-Cal & State Sponsored Programs Committee. The Plan also had designated staff who conducted and managed quality improvement projects and quality metrics specific to the Medi-Cal program.

The 2020 and 2021 Quality Program descriptions did not describe qualifications for regional quality department staff, Medi-Cal quality program staff, or relevant members from the regional quality committee or the two Medi-Cal quality committees.

As a corrective action to prior finding 5.1.1, the Plan updated the Medi-Cal & State Sponsored Programs Committee charter to include specific education, experience, and training of two Medi-Cal quality program staff members as well as a job description for the Physician Advisor role.

During the interview, the Plan stated the updated charter fulfilled the corrective action plan requirements. However, the 2020 and 2021 Quality Program descriptions did not contain the Medi-Cal & State Sponsored Programs Committee charter. In a written statement, the Plan stated the Medi-Cal & State Sponsored Programs Committee charter was omitted from the Quality Program Description in error.

When the Plan does not list the qualifications of staff responsible for the QIS, the Plan cannot ensure that qualified staff conduct and manage quality improvement activities.

This is a repeat of prior audit finding 5.1.1 Quality Program Description.

Recommendation: List the qualifications, including education, experience, and training, of staff responsible for quality improvement studies and activities in the Quality Program description.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

Sacramento and San Diego GMC

6.2.1 Source of Complaint

The Plan is required to submit fraud reports to DHCS. The reports must include the source of complaint. *(Contract, Exhibit E, Attachment 2, (25) (B) (7))*

Plan policy *NATL.NCO.011*, *Fraud, Waste, and Abuse Control (effective 07/02/2021),* stated that the Plan is committed to complying with all laws and regulations associated with the control of fraud, waste, and abuse.

Finding: The Plan did not include the source of complaint in fraud reports submitted to DHCS.

A verification study revealed fraud reports in 20 of 30 cases reported to DHCS did not include the source of complaint.

By not including the source of complaint, the Plan is out of compliance with the Contract.

Recommendation: Ensure fraud reports submitted to DHCS include the source of complaint.

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

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

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

State Supported Services

Audit Period: September 1, 2019
Through
October 31, 2021

Report Issued: March 3, 2022

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INTRODUCTION

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

The review was conducted from November 1 through November 12, 2021.
The audit period is September 1, 2019 through October 31, 2021 and consisted of document review of materials supplied by the Plan and interviews of Plan staff.

20 (Ten Sacramento GMC and ten San Diego GMC) State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: September 1, 2019 to October 31, 2021
DATE OF AUDIT: November 1, 2021 to November 12, 2021

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes: 59840 through 59857*
HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING(S):

There were no deficiencies identified in the current audit.

RECOMMENDATION(S):

None