



Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members

Provider Quick Reference Guide

2	Executive Summary and Medi-Cal Program Overview	8	Fraud, Waste, and Abuse	11	Pharmaceutical Management
3	Acupuncture	8	Health Education	12	Primary Care Physician (PCP) Assignment
3	Alternative Birthing Centers and Certified Nurse Midwives	8	Initial Health Assessments / Individual Health Education and Behavioral Assessments	12	Provider Preventable Conditions
3	Care Coordination	9	Language Assistance / Interpreter Services	12	Provider Suspension, Termination, or Decertification
5	Child Health and Disability Prevention and Early Periodic Screening, Diagnosis, and Treatment Programs	9	Managed Long-Term Services and Supports	12	Punitive Action Prohibitions
6	Chiropractic Benefits	10	Medical Decisions	13	Sensitive Services
7	Confidentiality and Protection of Privacy	10	Member/Provider Complaints, Grievances & Appeals	13	Sterilization
7	Cultural Competency / Sensitivity Training	10	Member Rights and Responsibilities	13	Transportation
7	Durable Medical Equipment Coverage	11	Minor Consent Services	14	Utilization Management
8	Facility Site Review				Vision Benefits

While Kaiser Permanente's (KP) Medi-Cal members receive most of the same services as KP's Commercial and Medicare members, there are some differences. This quick reference guide aims to inform providers and their staff about unique benefits or processes related to serving KP's Medi-Cal members.

- For general questions about Medi-Cal, please email KP's Medi-Cal Regulatory Oversight team at MediCalNCAL@kp.org
- To speak with a consultant regarding Medi-Cal benefits, please contact KP's Member Service Contract Center at 1-800-464-4000

Executive Summary and Medi-Cal Program Overview

The following information has been compiled to provide you with an orientation to Kaiser Permanente’s (KP) participation in California’s Medicaid Program, known as Medi-Cal. The Medi-Cal program is a public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities and pregnant women. Medi-Cal is financed equally by the state of California and the federal government. KP’s participation in Medi-Cal Managed Care is fundamental to our mission to improve the health of the communities we serve, supporting our tax-exempt status, maintaining our credibility in state and federal policy arenas, helping our membership growth and supports our retention strategy.

Across California, Medi-Cal accounts for approximately 8% of KP’s total membership. Of that, approximately 40% of KP California’s Medi-Cal members are served by the Northern California Region. The Permanente Medical Group, Inc. (TPMG) has earned distinction for the degree in which our program addresses the health needs of our Medi-Cal members. Once enrolled as a KP member, Medi-Cal members receive KP membership cards which are 100% identical to other KP membership cards. There is no difference between the provider network used by KP Medi-Cal, commercial, and Medicare members.

Kaiser Foundation Health Plan (KFHP) contracts directly with the Department of Healthcare Services (DHCS) for our GMC-Sacramento program (for which we are the Plan and provider). KP also contracts with Medi-Cal Managed Care plan partners (Table 1) to be a provider of services for Medi-Cal members through TPMG.

Administration of the program is a function of both The Permanente Medical Group (TPMG) and KFHP.

TABLE 1: KP Northern California Region Medi-Cal Participation

Medi-Cal Contract	Impacted Kaiser Permanente Medical Center/Office		Counties Served
Alameda Alliance for Health (AAH)	<ul style="list-style-type: none"> ✓ Fremont Medical Center ✓ San Leandro Medical Center ✓ Livermore Medical Offices 	<ul style="list-style-type: none"> ✓ Oakland Medical Center ✓ Pleasanton Medical Offices 	Alameda
Contra Costa Health Plan (CCHP)	<ul style="list-style-type: none"> ✓ Antioch Medical Center ✓ Martinez Medical offices 	<ul style="list-style-type: none"> ✓ Pinole Medical Offices ✓ Richmond Medical Center 	Contra Costa
Geographic Managed Care (GMC)	<ul style="list-style-type: none"> ✓ Elk Grove Medical Offices ✓ Folsom Medical Offices ✓ Lincoln Medical Offices ✓ Rancho Cordova Medical Offices 	<ul style="list-style-type: none"> ✓ Roseville Medical Center ✓ Sacramento Medical Center ✓ Fair Oaks Medical Center ✓ Point West Medical Offices ✓ So. Sacramento Medical Ctr. 	Amador, El Dorado, Placer, and Sacramento
Partnership Health Plan of CA (PHC)	<ul style="list-style-type: none"> ✓ San Rafael Medical Center 		Marin
	<ul style="list-style-type: none"> ✓ Napa Medical Center 		Napa
	<ul style="list-style-type: none"> ✓ Fairfield Medical Offices ✓ Vacaville Medical Center 	<ul style="list-style-type: none"> ✓ Vallejo Medical Center 	Solano
	<ul style="list-style-type: none"> ✓ Petaluma Medical Center ✓ Richard Stein Medical Offices 	<ul style="list-style-type: none"> ✓ Rohnert Park Medical Ctr. ✓ Santa Rosa Medical Center 	Sonoma

Santa Clara Family Health Plan (SCFHP)	<ul style="list-style-type: none"> ✓ Campbell Medical Offices ✓ Gilroy Medical Offices ✓ Milpitas Medical Offices 	<ul style="list-style-type: none"> ✓ Mountain View Medical Offices ✓ San Jose Medical Center ✓ Santa Clara Medical Offices 	Santa Clara
San Francisco Health Plan (SFHP)	<ul style="list-style-type: none"> ✓ San Francisco Medical Ctr. 		San Francisco
Health Plan of San Joaquin (HPSJ)	<ul style="list-style-type: none"> ✓ Stockton Medical Offices ✓ Tracy Medical Offices 	<ul style="list-style-type: none"> ✓ Modesto/Manteca Medical Center 	San Joaquin
Health Plan of San Mateo (HPSM)	<ul style="list-style-type: none"> ✓ Redwood City Medical Ctr. ✓ San Mateo Medical Offices 	<ul style="list-style-type: none"> ✓ So. San Francisco Medical Ctr. 	San Mateo

Acupuncture

All Medi-Cal Managed Care (MMC) members are covered for acupuncture when medically indicated to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.¹ Members may self-refer to American Specialty Health Plan (ASH) by contacting ASH Member Services at 1-800-678-9133.

Alternative Birthing Centers, Certified Nurse Midwives, and Licensed Midwives

KP is required to provide our Medi-Cal managed care members with access to Comprehensive Perinatal Services Program-certified freestanding Alternative Birthing Centers, as well as to services provided by Certified Nurse Midwives and Licensed Midwives, if requested by the member. If a member requests any of the services listed above, please direct them to their Ob/GYN.

Care Coordination

DHCS requires KP to coordinate linked and carved-out services for its Medi-Cal members, including referrals to community resources and other agencies, when appropriate. These services include, but are not limited to:

→ Behavioral Health

KP is responsible for the delivery of non-specialty mental health services for Medi-Cal members under the age of 21 and outpatient mental health services to adult Medi-Cal members with mild to moderate levels of mental health impairment, as outlined in DHCS All Plan Letter (APL) 17-018. Members may be managed by Primary Care Providers, within their scope of practice, or KP Behavioral Health, as appropriate. Medi-Cal Managed Care members are referred by KP Behavioral Health to the local county mental health department for specialty services, including inpatient and outpatient specialty mental health services for members with severe mental health issues, wraparound and other Short-Doyle mental health services, and to the county addiction programs for substance use disorders. KP Behavioral Health assesses Medi-Cal members' level of treatment need and refers to county programs based on clinical necessity. Referral process to county behavioral health programs may vary by facility and county.² Providers should contact their local KP Behavioral Health departments for assistance with Medi-Cal members' behavioral health needs.

→ Alcohol Misuse: Screening and Behavioral Counseling (AMSC)

KP must screen Medi-Cal members ages 18 and older for alcohol misuse at least once per year. When, during the screening process, a member is identified as being engaged in risky or hazardous drinking, KP must offer

members with at least one behavioral counseling intervention per year. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling. KP must ensure that members who, upon screening and evaluation, meet the criteria for an alcohol use disorder, or whose diagnosis is uncertain, are appropriately referred to county mental health and/or alcohol use disorder services.³

→ Applied Behavioral Analysis Services

KP is required to cover medically necessary Behavioral Health Treatment (BHT) / Applied Behavioral Analysis (ABA) services for Medi-Cal members under 21 years of age. The Medi-Cal member must have a recommendation from a licensed physician, surgeon, or psychologist that evidenced-based BHT services are medically necessary. In addition, the member must be medically stable and not in need of 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.⁴

→ California Children's Services

KP must facilitate identification and referral of children with eligible conditions to California Children's Services (CCS).⁵ KP has paneled providers at certified sites and CCS coordinators in each services area. Once identified and referred, all medical care, diagnostic services, hospitalizations, and any durable medical equipment associated with the CCS condition are covered by the CCS program. Only care related to the CCS condition is carved out of coverage; all medically necessary covered services unrelated to the CCS condition remain the responsibility of KP. KP continues to provide all medically necessary covered services for the member's CCS eligible condition until the local county CCS Program confirms CCS eligibility by generating an authorization. If a physician identifies a Medi-Cal member under the age of 21 with a CCS-eligible condition, the physician must notify their regional CCS coordinator immediately to ensure timely submission of the referral to the CCS program. CCS-eligible conditions include chronic medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, congenital heart defect, cancer, etc.; a brief summary list is available at www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx

→ Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are defined as "children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally." KP must ensure that each CSHCN member receives a comprehensive assessment of health and related needs, and that all medically necessary follow-up services are documented in KP HealthConnect, including needed referrals.⁶

→ Coordination with Local Education Agency Services

KP's primary care providers shall cooperate and collaborate with Local Education Agencies (LEAs) in the development of Individual Education Plans (IEPs) or Individual Family Service Plans for its Medi-Cal members.⁷

→ Developmental Disabilities

KP shall refer members with developmental disabilities to a Regional Center for evaluation. The Association of Regional Center Agencies (ARCA) represents the community-based network of regional centers which provides lifelong services to over 280,000 individuals with developmental disabilities in California. Thousands of the individuals served by regional centers are children with both a developmental disability and other medical conditions that may make them eligible for California Children's Services (CCS). The vast majority of these children rely primarily on CCS and Medi-Cal funding for primary, specialty, and subspecialty medical and medical equipment services.⁸

→ Early Intervention Services/Early Start Program

KP must also identify children who may be eligible for a referral to a local Early Start program to address developmental delays. KP is required to cover/provide all medically necessary speech, occupational, and physical therapy services for Medi-Cal members with a developmental delay regardless of age.⁹ The Early Start program provides a wide range of services for infants and children three years or under, who have developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional and adaptive functions. Please feel free to reach out to the specialists at your sites for specific questions on the program or to make a referral. You may also see the Early Start Internal Website for additional Early Start Information: <https://earlystartresources.kaiserpermanente.org/>

→ Health Homes Program

Health Homes is a care management program available to Medi-Cal members with certain conditions and acuity and/or those experiencing homelessness. If you have a member who may benefit from enhanced care management services, contact KP's Medi-Cal Regulatory Oversight team at MediCalNCAL@kp.org to see if the member would qualify. If the member does qualify, KP will work with the member to explain the program and enroll the member if the member agrees. For members experiencing homelessness, the program includes housing navigation services.¹⁰

→ HIV/AIDS

KP is responsible for the identification and referral of Medi-Cal members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program.¹¹ For more information on Medi-Cal waiver programs please visit: <https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx>

→ Dental

While dental services are covered through Denti-Cal, primary care providers are responsible for ensuring members under 21 years of age receive dental screenings/oral health assessments. Annual dental referrals to Denti-Cal should begin with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.¹²

→ Women, Infants, and Children Supplemental Nutrition Program

The Women, Infants, and Children Supplemental Nutrition Program (WIC) is a nutrition/food program that helps pregnant, breastfeeding, or postpartum women and children less than 5 years of age to eat well and stay healthy. KP is responsible for the referral of Medi-Cal members to WIC, if need is identified during the evaluation of a pregnant, breastfeeding or postpartum member, or of a child under the age of five (5).¹³

→ Major Organ Transplant Services

DHCS requires that members approved for major organ transplants be disenrolled from Medi-Cal Managed Care upon receipt of the transplant authorization, except for kidney-only and corneal transplants. After the transplant, a member may be re-enrolled if the member meets KP's Permission to Enroll (PTE) criteria.¹⁴ Providers or their clinic staff should contact the Transplant Coordinator for their facility for assistance with transplant services, or the Transplant HUB at 888-551-2740.

Child Health and Disability Prevention and Early Periodic Screening, Diagnosis, and Treatment Programs

The Child Health and Disability Prevention (CHDP) Program is a state and county public health program designed to assure eligible children and youth receive periodic health assessments and have access to

ongoing health care from a medical home.¹⁵ California's CHDP program fulfills the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for Medi-Cal members under age 21.

KP providers are required to comply with CHDP Health Assessment Guidelines for all routine or non-urgent pediatric office visits. KP uses the Bright Futures™ guidelines for pediatric preventive care and screenings, which are built into KP's electronic health record systems, KP HealthConnect. Primary care is responsible for:

- Documenting periodic screenings in KP HealthConnect
- Providing copies of the visit to the parent or guardian

Under the EPSDT program, KP must provide comprehensive screening, vision, dental, and hearing services at intervals that meet reasonable standards of medical/dental practice and as medically necessary as well as other necessary health care, diagnostic services, treatment, and measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services for individuals under the age of 21 who are enrolled in Medi-Cal. While dental services are carved out of the Medi-Cal Managed Care contract, KP must provide dental screenings during the Initial Health Assessment (IHA) and during periodic assessments for members under the age of 21. KP is responsible to ensure members are referred to appropriate Medi-Cal dental providers, and for the provision of covered medical services not provided by dentists or dental anesthetists.¹⁶

EPSDT services include the provision of medically necessary BHT services to members under 21 years of age.¹⁷

Chiropractic Benefits

KP received confirmation from DHCS in November 2018 that Chiropractic Services for certain beneficiaries is a mandated covered benefit under Medi-Cal Managed Care that may not be subject to prior authorization or referral requirements.

At the direction of both DHCS and the Department of Managed Health Care (DMHC), the California Medi-Cal EOCs were revised, effective July 1, 2018, to include coverage for certain chiropractic services in all KP Cal, LLC, and KFHP Medi-Cal contracts. Previously, we covered chiropractic services only in certain counties. Now, certain members have coverage for chiropractic services regardless of which Medi-Cal contract they are enrolled in.

DHCS also provided direction that chiropractic services must be covered in accordance with the DHCS Provider Manual, which imposes limits on the number of visits and the populations who are eligible for coverage. Covered chiropractic services are limited to manual manipulation of the spine for up to two visits per calendar month. If a provider determines it is medically necessary for a member to receive more than two visits in a calendar month, a treatment authorization will be provided by ASH to the rendering provider. Please note that coverage does not include chiropractic appliances.

The populations eligible for coverage of chiropractic services are defined in the Welfare and Institutions Code. They include the following groups:

- Individuals under 21 years old
- Pregnant mothers
- Members residing in Skilled Nursing Facilities/Intermediate Care Facilities
- All members treated through Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs)

The member would contact ASH to determine eligibility. ASH shall manage medical necessity beyond the two visits per calendar month requirement and the member intake process to identify those Medi-Cal beneficiaries covered pursuant to the Medi-Cal Provider Manual. Members can call ASH directly at 1-800-678-9133 (8 a.m. to

5 p.m. PST) to request a list of providers near them or for more information they can go on the website: www.ashlink.com

Confidentiality and Protection of Privacy

KP employees and physicians are required to maintain the confidentiality of member information.¹⁸ This obligation is addressed in policies and procedures and confidentiality notices and agreements. All providers with whom KP contracts are subject to the Program's confidentiality requirements. KP has developed and distributed to members a Notice of Privacy Practices describing members' privacy rights and KP's obligation to protect members' health information.

Members have the right to privacy. KP will not release protected health information (PHI) without written authorization, except as required or permitted by law. If the member/patient is unable to provide authorization, the member's legally authorized representative may provide authorization for the release of information on the member's behalf. Member-identifiable PHI is shared with employers only with the member's permission or as otherwise required or permitted by law.

Members have a right to access their own PHI, as provided by law. Members also have the right to authorize, in accordance with applicable law, the release of their own PHI to others.

KP may collect, use, and share personal information (including race, ethnicity, language preference, and religion) for treatment, health operations, and for other routine purposes, as permitted by law, such as for use in research and reducing health care disparities. Any breach of patient information must be reported immediately to the Compliance Hotline at 1-888-774-9100.

Cultural Competency / Sensitivity Training

KP ensures that all medically necessary covered services are available and accessible to all Medi-Cal members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or group defined in Penal Code 422.56 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=422.56.&lawCode=PEN), and that all covered services are provided in a culturally and linguistically appropriate manner.¹⁹

A mandatory online training is required for providers and employees who interact with Seniors and Persons with Disabilities (SPD) members. The training increases sensitivity and awareness of persons with disabilities and is part of New Physician Orientation.

California and Federal laws require that KP provides Limited English Proficient members with 24/7 access to qualified language assistance services. Onsite and telephone/video interpreters are available; this is further described under Language Assistance/Interpreter Services on page 9.

KP is committed to providing equal access to our facilities and services for people with disabilities. This includes full compliance with the Americans with Disabilities Act (ADA), federal, state, and regulatory requirements in making all facilities, services, and programs accessible in a timely and effective manner. For more information, visit KP's ADA compliance web site: <https://sp-cloud.kp.org/sites/teams-ccb/CRCompliance/SitePages/Civil%20Rights%20Compliance.aspx>

Durable Medical Equipment Coverage

Medi-Cal coverage for Durable Medical Equipment (DME) may cover some items not usually covered by other insurance or Medicare. Examples include incontinence supplies, shower benches, and some types of wheelchairs. Medi-Cal's guidelines for how often a member may receive certain items may be found at:

[http://cl.kp.org/ncal/home.html?memberage=N&category=N&doctype=Patient%2520Care%2520Resources&sdtype=DME %2520Prosthetics%2520and%2520Orthotics&location=PatientCareResources](http://cl.kp.org/ncal/home.html?memberage=N&category=N&doctype=Patient%2520Care%2520Resources&sdtype=DME%2520Prosthetics%2520and%2520Orthotics&location=PatientCareResources)

Orders for DME items for Medi-Cal members should be placed through KP HealthConnect. For specific questions about the DME formulary or Prosthetic and Orthotic (P&O) clinical criteria, contact your local DME department.

Facility Site Review

Outpatient clinics undergo a triennial review to become recertified for Medi-Cal Managed Care participation. The survey is comprised of three parts: Facility Site Review of clinics that provide primary care; Medical Record Review for adult, pediatric and obstetrical care; and, physical accessibility for members including those with disabilities.

Fraud, Waste, and Abuse

Providers and their staff must be trained annually on fraud, waste, and abuse, in compliance with state and federal requirements.²⁰ The current training module is available on KP Learn. Go to <http://learn.kp.org> and search for "Annual Compliance Training." To report a concern related to fraud, waste, or abuse, call the Compliance Hotline at 1-888-774-9100.

Health Education

KP is required to maintain a robust health education system for Medi-Cal members, including educational workshops, telephonic wellness coaching, consultation, support groups, and print as well as online health information.²¹ Through this system, Medi-Cal members are provided information, tools and resources to improve health, support behavior change/lifestyle management, and better manage disease. Providers may download health education resources from KP's Clinical Library at <https://cl.kp.org/ncal/home.html>

Providers can refer members to health education services or order online educational videos through the member's medical record. Members may also access health education services in-person at a local Health Education department, on kp.org or via phone. To learn more about Health Education programs and services, please visit <https://kp.org/rhe>

Initial Health Assessments / Individual Health Education and Behavioral Assessments

New Medi-Cal members shall receive an Initial Health Assessment (IHA) to be completed within 120 days of enrollment in Medi-Cal. The IHA periodicity schedule is incorporated into KP HealthConnect and programmed to auto-remind providers when assessments are due. A complete IHA includes administration of the age-appropriate Individual Health Education Behavioral Assessment (IHEBA).²² For adult Medi-Cal members, KP uses the DHCS approved Alternative IHEBA form, the Staying Healthy Assessment (SHA). For pediatric Medi-Cal members, KP uses the Bright Systems forms as an alternative to the Staying Healthy Assessment. The Member Outreach and Integration and the Sacramento Area Geographic Managed Care departments provide the IHEBA/SHA form to the member via phone and mail. When completed, via mail or in the primary care physician's office forms are scanned into KP HealthConnect. The primary care physician must prioritize and document each member's health education needs and initiate discussion and counseling about high risk behaviors. IHEBA/SHA refusal should be documented in the member's medical record in KP HealthConnect.

During the IHA visit, PCPs are responsible for reviewing each member's IHEBA with the member and/or parent/guardian in combination with the following relevant information:

- Medical history, conditions, problems, medical/testing results, and member concerns.
- Social history, including member’s demographic data, personal circumstances, family composition, member resources, and social supports.
- Local demographic and epidemiologic factors that influence risk status.

The PCP shall prioritize and document each member’s health education needs and initiate discussion and counseling regarding high-risk behaviors. Based on the member’s behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Clinic staff members may assist with counseling and follow-up under the supervision of the PCP.

→ SHA Documentation

- SHA refusal should be documented in the member’s file in KP HealthConnect.
- The PCP should acknowledge he/she reviewed the completed SHA form in KP HealthConnect.
- The PCP should document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided by documenting in KP HealthConnect.

Language Assistance / Interpreter Services

KP requires all staff to comply with the Kaiser Permanente Language Assistance Program (LAP) guidelines for all KP members who are limited English proficient (LEP), including members who require sign language services. High quality and timely language assistance that is free of charge and available 24 hours/day, 7 days/week or during all hours of business must be provided to all KP members.²³

Further information on KP’s Language Assistance Program is available on the Regional Language Access Program website at <https://wiki.kp.org/wiki/display/ncaldiversity/Home>.

Any questions regarding language assistance can be discussed with KP’s Language Assistance Program by calling (510) 987-3422, or by emailing NCAL-Language-Assistance-Program@kp.org.

Managed Long-Term Services and Supports (MLTSS)

MLTSS encompasses several services, including: Community-Based Adult Services (CBAS), Long Term Care (LTC), Multi-purpose Senior Support Programs (MSSP), and In-Home Supportive Services (IHSS). Eligibility for these programs often requires an assessment and pre-authorization.

In KP NCAL, depending on the service and county, MLTSS are coordinated and/or paid for through KFHP, the county, the state, or the plan partner.

→ Community-Based Adult Services

The Community-Based Adult Services program (CBAS) is intended to help members maintain the highest possible level of functioning in a community environment as opposed to placement in a nursing facility. This facility-based service provides Adult Day Health Care services to Medi-Cal members who meet medical necessity criteria. Members may attend between one to five days a week, and transportation to and from home is provided. To inquire about CBAS for KP-assigned GMC Sac, Alameda Alliance for Health, or Health Plan of San Joaquin members, contact the Medi-Cal Clinical Decision Unit at 1-866-842-2574; or for other Medi-Cal members, refer members to their respective plan partner.

→ Long Term Care

For managed Medi-Cal, Long Term Care (LTC) includes admission to an intermediate, skilled, or sub-acute care facility, that extends to the month following admission, if members meet Medi-Cal clinical criteria. Coordination and/or payment for LTC is either by managed care plan or fee-for-service, depending on the county.

→ Multi-purpose Senior Support Programs

Multi-purpose Senior Support Programs (MSSP) provide care management and coordinate community services for Medi-Cal members who are 65 years or older and disabled, as an alternative to nursing facility placement. Examples include respite care, additional personal care services, and meals. Coordination for MSSP is either by the managed care plan or the county; payment is by the county. Primary Care may advise members in need of MSSP to contact their local MSSP office for assistance.

→ In Home Support Services

In Home Support Services (IHSS) are for Medi-Cal members who need assistance with Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL) to live safely in their homes. Examples of IHSS may include meal prep and clean up, laundry services, bathing and grooming assistance, grocery shopping, running errands, escort to medical appointments, household and yard cleaning, and protective supervision. Coordination for MSSP is either by the managed care plan or the county; payment is by the county. Primary care may advise members in need of IHSS to contact their local IHSS office for assistance.

Medical Decisions

KP must ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.²⁴ KP does not reward providers or other individuals for issuing denials of coverage. Additionally, financial incentives for utilization management (UM) decision makers do not encourage decisions that result in underutilization.

Member/Provider Complaints, Grievances & Appeals

Members are encouraged to bring their concerns to the attention of their PCP first. Member Grievance procedures are included in the Member Handbook that is mailed to each member upon enrollment.

Member Rights and Responsibilities

Medi-Cal members have the following rights, guaranteed to them by DHCS:

- To be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information.
- To be provided with information about KP and its services.
- To be able to choose a Primary Care Provider within KP's network.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive oral interpretation services for their language.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services, and emergency services outside KP's network pursuant to Federal law.

- To request a state Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend, or correct their medical record.
- To change Medi-Cal Managed Care Health Plans upon request, if applicable.
- To access services for which a minor alone may legally consent; these are described in the Minor Consent Services section below.
- To receive written member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with California Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Freedom to exercise these rights without adversely affecting how they are treated by KP, providers, or the state.
- To file a request for an appeal of an action within 60 days of the date on a Notice of Action (NOA).²⁵

If a member expresses dissatisfaction with the treatment plan and/or with a provider's response to the member's request for a service/item, and the provider is unable to resolve the issue, it is appropriate to remind the patient of his/her right to file a grievance with Member Services.

Minor Consent Services

Under California law, members under the age of 18 have the right to access some services without parental consent. Medical records and/or information regarding medical treatment specific to these services must not be released to the parent(s) or guardian(s) without the minor's consent. These services include:

- Sexual assault, including rape
- Drug and alcohol abuse for children 12 years of age or older.
- Pregnancy services, including abortion
- Family planning services
- Sexually transmitted disease and HIV/AIDS diagnosis and treatment in children 12 years of age or older
- Outpatient mental health for children 12 years of age or older who are mature enough to participate intelligently and where either (a) there is danger of serious physical or mental harm to the minor or others, or (b) the child is the alleged victim of incest or child abuse.²⁶

Pharmaceutical Management

Medically necessary drugs, supplies, and supplements are covered by KFHP for Medi-Cal Managed Care members based on the KP Drug Formulary guidelines and Medi-Cal coverage criteria. The KP Online Drug Formulary is the source for formulary and drug information and can be accessed on-line at: <http://pharmacy.kp.org/> (Click on the "Online Formulary" tab on the left-hand side.)

Select over-the-counter (OTC) medications are covered under Medi-Cal. They must be ordered as a prescription and are fulfilled in KP pharmacies.

Kaiser Permanente shall ensure the provision of at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency situation.

Primary Care Physician (PCP) Assignment

New members are assigned a PCP within 40 days of member enrollment and are notified via postal letter. New members who choose their personal physician have their choice confirmed at the time of their selection (on the phone or online).

PCPs may refer Medi-Cal patients to specialists, when medically necessary. The PCP should work with the patient to choose a specialist and the PCP's office should help the patient schedule the appointment.

Examples of Specialists that require a referral include:

- Surgery
- Orthopedics
- Cardiology
- Oncology
- Dermatology
- Physical, occupational, and speech therapies

Provider Preventable Conditions

DHCS prohibits payment of Medi-Cal funds to a provider for the treatment of a provider-preventable condition (PPC), except when the PPC existed prior to the initiation of treatment for the Medi-Cal member by that provider. As such, DHCS requires KFHP to report PPCs that are associated with claims for Medi-Cal payment or for courses of PPC treatment prescribed to a Medi-Cal member for which payment would otherwise be available. PPCs that existed prior to the initiation of treatment of the member by the provider are not reportable.²⁷

After discovery of a PPC and confirmation that the patient is a Medi-Cal beneficiary, KP must report the PPC to the DHCS using the following website: <https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx>.

Provider Suspension, Termination, or Decertification

KP must ensure timely compliance with all requirements associated with DHCS notification of a provider's suspension, termination, or decertification from participation in the Medi-Cal programs.²⁸

Punitive Action Prohibitions

KP may not take punitive action against a provider who either requests an expedited resolution or supports a Member's appeal. Further, KP may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of a Member, who is their patient, as follows:

- For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- For any information the member needs to decide among all relevant treatment options
- On the risks, benefits, and consequences of treatment or non-treatment
- For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.²⁹

Sensitive Services

Sensitive Services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortion. Sensitive Services must be made available without a referral or authorization to protect patient confidentiality and to promote ease of access. Medi-Cal members may access local health and/or family planning providers for sensitive services without prior authorization from KP, regardless of network affiliation.³⁰ Out of plan providers (e.g., Planned Parenthood) must submit claims to KP for reimbursement.

Sterilization

California law requires that Medi-Cal members requesting sterilization services meet the following criteria:

- Be at least 21 years of age at the time consent is obtained
- Not be mentally incompetent
- Be able to understand the content and nature of the informed consent process
- Not be institutionalized
- Have voluntarily given their written informed consent using the PM 330 form noted below
- At least 30 days, but not more than 180 days, have passed between the date of written informed consent and the date of sterilization, subject to very limited exceptions

As indicated above, members requesting sterilization services must complete a form (PM 330) attesting that they are giving informed consent for sterilization services: https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf

The PM 330 form is completed by the member and KP nurse or physician, scanned into KP HealthConnect, and saved under the "Media" tab. After the 30-day waiting period and before the sterilization procedure (which must occur not more than 180 days from the date the member completed the PM 330 form), the PM 330 form is printed from KPHC and the Physician Section of the consent is completed and then re-scanned into the member's medical record in KPHC. Medi-Cal members may not waive the 30-day waiting period for sterilization.³¹

For more information, refer to KP's ambulatory practice website: <https://www.ambulatorypractice.org>

Transportation

In addition to emergency medical and non-emergency ground/air ambulance, KP covers non-emergent medical transportation (NEMT), and non-medical transportation (NMT) for Medi-Cal members.³²

- NEMT: Available to Medi-Cal members requiring covered medical services, but for whom traditional means of private or public transportation is medically contraindicated by the member's medical or physical condition. Contact KP's NCAL Regional Transportation HUB at 1-800-438-7404 for assistance.
- NMT: Available to all Medi-Cal members requiring transportation to and from health care services covered by KP and/or Medi-Cal. Unlike NEMT, there does not need to be a medical necessity for NMT, just a need for transportation and the member has no other options. Providers or their staff may direct the Medi-Cal member to call KP Transportation Services at 1-844-299-6230, TTY services dial 711. Medi-Cal members may also contact the Member Services Contact Center or Local Member Services for assistance with NMT.

Utilization Management (UM)

Utilization review is a process that determines whether a health care service recommended by the treating provider is medically necessary. If it is medically necessary, the services will be authorized, and the member will receive the services in a clinically appropriate place consistent with the terms of the

member's health coverage. Utilization Management (UM) activities and function include the prospective, retrospective, or concurrent review of health care service requests submitted by providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medical necessity. KP's utilization review program is subject to direct regulation under the Knox-Keene Act and must adhere to managed care accreditation standards.

What you need to know:

- Prior authorization is needed for outside services (transplant, outside second opinions) and certain DME items.
- If coverage request is denied, members will be provided with a timely denial letter with a clear explanation regarding the decision and appeal rights, and the requesting clinician must be notified of the denial.
- Members can appeal UM denials to external regulatory agencies, depending on coverage type, for independent review.
- Members may submit grievances to Member Services if they are not being offered care they believe is needed or to request a second opinion not recommended by the treating physician.

Vision Benefits

→ Eye Exams

Members are covered for eye exams to determine if they need eyeglasses and to provide a prescription for eyeglasses.

→ Eyeglasses, Lenses, and Frames

Eyeglasses (frame and lenses) may be covered every 24 months when a member has a prescription of at least 0.75 diopter. Members should check their Evidence of Coverage annually to confirm benefit.

New or replacement eyeglass lenses may be provided by the state. Members should check their Evidence of Coverage (EOC) annually to confirm their benefit. KP may provide an allowance for new or replacement frames. Members should refer to their EOC for benefit details.

→ Special Contact Lenses

KP may cover contact lenses under certain conditions:

- For aniridia (missing iris), up to two medically necessary contact lenses (including fitting, and dispensing) per eye every 12 months at no charge;
- One pair of medically necessary contact lenses (other than contact lenses for aniridia) every 24 months at no charge. Contact lenses are covered only if a Kaiser Permanente plan doctor or Kaiser Permanente plan optometrist finds that they will give a member much better vision than they could get with eyeglasses alone. We cover replacement of medically necessary contact lenses within 24 months if your contact lenses are lost or stolen.

General information regarding Medi-Cal and State Programs may be found on KP Infosource:

<https://sites.sp.kp.org/services/infosource/lines-of-business/medi-cal-state-programs-subsidized-plans>.

References

- ¹ MMCD APL 16-015
- ² MMCD APL 17-018
- ³ MMCD APL 18-014
- ⁴ MMCD APL 19-014
- ⁵ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 9
- ⁶ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 8
- ⁷ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 12
- ⁸ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 10
- ⁹ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 11
- ¹⁰ MMCD APL 19-010
- ¹¹ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 14
- ¹² DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 15
- ¹³ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 17
- ¹⁴ DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 18.A
- ¹⁵ DHCS CHDP Provider Manual (http://files.medi-cal.ca.gov/pubsdoco/chdp_manual.asp)
- ¹⁶ MMCD APL 19-010
- ¹⁷ MMCD APL 19-010; MMCD APL 19-014
- ¹⁸ DHCS Contract Boilerplate, Exhibit G
- ¹⁹ DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 13.D; MMCD APL 17-011
- ²⁰ DHCS Contract Boilerplate, Exhibit E, Attachment 2, Section B.1
- ²¹ DHCS Contract Boilerplate, Exhibit A, Attachment 10, Section 8

- ²³ DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 14; Health & Safety Code Section 1367.04
- ²⁴ DHCS Contract Boilerplate, Exhibit A, Attachment 1, Section 5
- ²⁵ DHCS Contract Boilerplate, Exhibit A, Attachment 13, Section 1
- ²⁶ DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9
- ²⁷ DHCS Contract Boilerplate, Exhibit A, Attachment 8, Section 15; MMCD APL 17-009
- ²⁸ MMCD APL 16-001
- ²⁹ DHCS Contract Boilerplate, Exhibit A, Attachment 7, Section 8
- ³⁰ DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9
- ³¹ DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9.A; Title 22 CCR Sections 51305.1 & 51305.3
- ³² MMCD APL 17-010 (Revised)