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

Contracted Provider Quick Reference Guide

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 Strategy and State Programs team at Medi-Cal-State-Program@kp.org
- To speak with a consultant regarding Medi-Cal benefits, please contact KP's Member Service Contract Center at 1-800-464-4000

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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 60% of KP California's Medi-Cal members are served by the Southern California Region. The Southern California Permanente Medical Group, Inc. (SCPMG) 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 San Diego Geographic Managed Care (GMC) 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 SCPMG.

Administration of the program is a function of both KFHP and SCPMG.

TABLE 1: KP Southern California Region Medi-Cal Participation

Medi-Cal Contract	Impacted KP Medical Centers	Counties Served
CalOptima	✓ Anaheim Medical Center ✓ Irvine Medical Center	Orange
Geographic Managed Care (GMC)	✓ San Diego Medical Center ✓ Zion Medical center	San Diego
Gold Coast Health Plan	✓ Woodland Hills Medical Center	Ventura
Inland Empire Health Plan	✓ Fontana Medical Center ✓ Ontario Medical Center ✓ Riverside Medical Center	Riverside, San Bernardino
Kern Family Health Plan	✓ Kern County Medical Center ✓ Moreno Valley Medical Center	Kern
LA Care Health Plan	✓ Baldwin Park Medical Center ✓ Downey Medical Center ✓ Fontana Medical Center ✓ Los Angeles Medical Center ✓ Panorama City Medical Center ✓ South Bay Medical Center ✓ West Los Angeles Medical Center ✓ Woodland Hills Medical Center	Los Angeles, includes Antelope Valley

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 access to alternative or freestanding birthing centers and certified nurse midwives (CNM) to our Medi-Cal managed care members.[2] Alternative Birthing Centers (ABC) must be Comprehensive Perinatal Services Program (CPSP) certified to provide obstetrical and delivery services. If a member is interested in receiving pregnancy care at a CPSP birthing center, please refer them to Ob/Gyn for a pregnancy risk assessment. If the Medi-Cal member meets the low pregnancy risk criteria, a referral for prenatal, delivery, and postpartum services may be issued if a CPSP birthing center is located within the member's county.

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 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.[3] 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, provide further evaluation to confirm positive possible misuse screens, conduct behavioral counseling interventions, and appropriately refer to county mental health and/or alcohol use disorder services. KP must ensure that members with possible alcohol misuse are offered three behavioral counseling intervention(s) annually. These interventions may occur in-person, telephonically or via telehealth and are generally 15 minutes in duration per session.[4]

➔ 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.[5]

➔ California Children's Services

KP must facilitate identification and referral of children with eligible conditions to California Children's Services (CCS).[6] Once identified and referred, all medical care, diagnostic services, hospitalizations, and any durable medical equipment associated with the California Children's Services (CCS) condition are covered by the CCS program. Only care related to the CCS condition is carved out of coverage; all primary care and care not related to the CCS condition remains 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

- As of July 1, 2019, California Children Services (CCS) is carved into KP for CalOptima (Orange County) Medi-Cal children ONLY. KP is now responsible to provide, refer, and coordinate care for children with a CCS approved condition. If you have any questions, please contact Tederick Myles, RN, Regional Manager with the KP CCS team at 626-381-6103.

➔ 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.[7]

➔ 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.[8]

➔ 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.[9]

➔ 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.[10]

➔ Health Homes Program

Health Homes is a care management program available to Medi-Cal members with certain conditions and acuity and/or experiencing homelessness. If you have a member who may benefit from enhanced care management services, contact Medi-Cal and State Programs at Medi-Cal-State-Program@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 he/she desires. For members experiencing homelessness, the program includes housing navigation services.[11] A KP Medi-Cal member may also call Complex Case Management directly to inquire about eligibility at 1-866-551-9619 (TTY users call 711), Monday through Friday, 8 a.m. to 5:30 p.m.

➔ 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.[12] 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.[13]

➔ 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).[14]

➔ Major Organ Transplant Services

Beginning 1/1/2022, all major organ transplants are carved-in and no longer require disenrollment. KP is responsible for issuing transplant-related authorizations when adult members are referred to Medi-Cal approved transplant Centers of Excellence (COEs). Pediatric members who are referred to CCS-approved transplant COEs will require a CCS Service Authorization Request (SAR).

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, to minimize behavioral conditions and promote member function, to the maximum extent practicable.[17] Members ages 18-21 are also eligible for additional screening for Alcohol Misuse Screening, Counseling, and Behavioral Counseling under EPSDT benefits. [18]

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 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

Claims and Encounter Data Submission

Periodic reporting of encounter data is a requirement for Medi-Cal managed care providers. Contracted providers must ensure the complete, accurate, reasonable, and timely submission of claims and encounter data to KP. KP encourages the electronic submission of claims and encounter data. If you have questions about electronic submission, please contact the Southern California KP EDI Helpline at 1-866-285-0361.

Clinical Practice Guidelines

KP's Clinical Practice Guidelines (CPGs) are clinical references used to educate and support clinical decisions by practitioners at the point of care in the provision of acute, chronic, and behavioral health services. The use of CPGs by practitioners is discretionary. However, CPGs can assist providers in providing patients with evidence-based care that is consistent with professionally recognized standards of care.

The development of KP's CPGs is determined and prioritized according to established criteria which include: number of patients affected by a particular condition/need, quality of care concerns and excessive clinical practice variation, regulatory issues, payor interests, cost, operational needs, leadership mandates and prerogatives.

Physicians and other practitioners are involved in the identification of KP's CPG topics, as well as the development, review, and endorsement of all CPGs. The CPG team includes a core, multi-disciplinary group of physicians representing medical specialties most affected by the CPG topic, as well as health educators, pharmacists, or other medical professionals.

The KP CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the KP Guidelines Medical Director. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are available by contacting KP Member Services Call Center (MSCC) at 1-800-464-4000 or contacting the KP referring physician.

Additionally, the California Department of Health Care Services (DHCS) requires managed care plans, including Kaiser Foundation Health Plan, to inform contracted providers of additional guidelines published by the US Preventive Services Task Force (USPSTF). The current list of USPSTF's preventive services "A" and "B" recommendations are available online at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

For more information about the US Preventive Services Task Force, please visit: https://www.uspreventiveservicestaskforce.org/Page/Name/home

Confidentiality and Protection of Privacy

KP employees and physicians are required to maintain the confidentiality of member/patient information.[19] 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/patients 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/patient's legally authorized representative may provide authorization for the release of information on the member's/patient's behalf. Member-identifiable PHI is shared with employers only with the member's/patient's permission or as otherwise required or permitted by law.

Members/patients have a right to access their own PHI, as provided by law. Members/patients 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.

Continuity of Care (COC)

SB 133 of 2017 expands the circumstances in which a member may invoke Health and Safety Code Section 1373.96 Continuity of Care provisions to include enrollees in an individual health plan contract when that health plan benefit is withdrawn from the market. Previously these provisions were not available to members with individual health plan coverage for any reason. Continuity of care is also referred to as "completion of covered services" or "completion of covered care."

The law requires health plans, including KP, inform our providers about the continuity of care provisions within the law. Beyond the requirements of Section 1373.96, there are several situations that afford additional continuity of care rights to certain Medi-Cal populations, pursuant to various All Plan Letters issued by the Department of Health Care Services. If you have any questions about continuity of care laws or their applicability to any KP member under your care, feel free to call the KP Member Services Contact Center at 1-800-464-4000 and request a copy of the KP Completion of Covered Services policy.

Cultural Competency/Sensitivity

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, and that all covered services are provided in a culturally and linguistically appropriate manner. [20]

KP is committed to providing equal access to our facilities and services for people with disabilities. This includes full compliance of 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.

Contracted providers should access the Community Provider Portal Medi-Cal section to attest to having reviewed the Diversity, Cultural Competency, and Cultural Sensitivity Training: http://providers.kaiserpermanente.org/html/cpp_sca/medi_cal.html

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. In addition, there are guidelines for how often a member may receive certain items.

For members with Dual coverage, their primary coverage may cover above items; Medi-Cal is secondary coverage. For assistance with Medi-Cal DME benefits, please contact KP's Member Service Contact Center at 1-800-464-4000.

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 and Medical Record Review of clinics that provide primary care, and Physical Accessibility Reviews of all site to determine site accessibility, especially for members with disabilities.

Fraud, Waste, and Abuse

Providers and their staff must be trained on fraud, waste, and abuse, to comply with requirements of California's Medi-Cal regulator, the Department of Health Care Services (DHCS).[21] For more information, please

refer to KP's Annual Contract Practitioner Communication, or HMO Provider Manual. 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.[22] Through this system, Medi-Cal members are provided information, tools and resources to improve health, support behavior change/lifestyle management, and better manage disease. Members may access health education services in-person at a local Health Education department, on kp.org or via phone.

Initial Health Assessments / Individual Health Education and Behavioral Assessments

New Medi-Cal members must have an Initial Health Assessment (IHA) within 120 days of enrollment in Medi-Cal. A complete IHA consists of the following elements:

- Comprehensive history, including present illness, medical and social history, and review of organ systems
- Preventive services per clinical guidelines applicable to the member's age, gender, and health status (AAP and CHDP for children/adolescents; ACOG for women/perinatal; USPSTF and CDC for all populations); to access the current clinical practice guidelines refer to KP's Clinical Library at https://clm.kp.org/wps/portal/cl/SCAL
- Comprehensive physical and mental status exam, and dental/oral health assessment; includes alcohol misuse screening
- Diagnosis and plan of care, including follow-up
- Administration of the age-appropriate Individual Health Education Behavioral Assessment (IHEBA)[23]

For adult Medi-Cal members, KP uses the DHCS approved IHEBA form, the Staying Healthy Assessment (SHA). For pediatric Medi-Cal members, KP uses the Bright Futures SHA forms.

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 KP 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.[24]

Further information on KP's Language Assistance Program is available on the SCAL Diversity Resources web site at https://hrconnect.kp.org/wps/myportal/hr/workatkp/cultureanddiversity/diversityadditionallinks_scal/

For Translation Services, go to https://wiki.kp.org/wiki/display/translationservices/Home.

Managed Long-Term Services and Supports (MLTSS)

KP is required to provide MLTSS in Coordinated Care Initiative (CCI) counties, which include Los Angeles, Orange, Riverside, San Bernardino, and San Diego. In all other counties, the plan partner, the county, or the state provides these services.

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). If you identify a KP Medi-Cal member who may be eligible for any of these MLTSS services, please contact the Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711) for assistance. Department staff are available Monday through Friday from 8 a.m. to 5:30 p.m. For Special Needs Plan (SNP) members, please contact the local Special Needs Plan Team. See below:

Kaiser Permanente Southern California Region			
Medical Center SNP Program Main Telephone Numbers			
Medical Center	**SNP Main Tel #**	**Medical Center**	**SNP Main Tel #**
Antelope Valley	(866) 324-0010	**Riverside**	(951) 358-2664
Baldwin Park	(877) 347-5176 (626) 851-7046	**San Bernardino County**	(909) 609-3736
Downey	(562) 622-3820 (888) 215-4350	**San Diego**	(866) 300-0019
Kern	(661) 398-3855 (877) 524-7373	**South Bay**	(424) 251-7516
Los Angeles	(323) 783-3230	**West Los Angeles**	(323) 900-7500
Orange County	(714) 734-4590	**Woodland Hills**	(818) 592-2427
Panorama City	(866) 331-8042 (818) 375-2940		

➔ Community-Based Adult Services

This facility-based service provides Adult Day Health Care services to Medi-Cal members who meet medical necessity criteria. Community-Based Adult Services (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. Members may attend between one to five days a week, and transportation to and from home is provided.

➔ 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.

➔ 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.

➔ 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. 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.[25] 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

A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, any aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the health plan to make an authorization decision. An initial determination is a type of grievance which also includes a request for referral, provision of or reimbursement for services or supplies, or other financial resolution, regardless of how that dissatisfaction is submitted to KFHP.

Members, or an authorized representative acting on behalf of a member, may submit a Grievance or an Initial Determination in person, by phone 1-800-464-4000, by email or online through the KP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (PO Box 939001, San Diego, CA 92193) for investigation and resolution. KP does not limit the timeframe during which the member is eligible to submit a grievance or an initial determination. Standard grievances are processed within 30 calendar days. Initial determinations are processed within 14 to 30 calendar days, depending on the type of request. Expedited grievances and initial determinations are processed within 72 hours. The member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases.

An appeal is defined as a review of an initial adverse decision/Notice of Action. Members, or an authorized representative acting on behalf of a member, may submit an appeal in person, by phone 1-800-464-4000, by email or online through KFHP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (PO Box 939001, San Diego, CA 92193), for investigation and resolution. If the member or authorized representative files an appeal to a Notice of Action (NOA), the appeal may be filed verbally, but must be followed in writing. KFHP allows 60 calendar days from the date of the adverse benefit determination or the NOA for the member to file an appeal. If the member wants to continue care which the adverse benefit determination or the NOA is terminating, suspending, or reducing, KFHP allows 10 calendar days from the postmarked date of the adverse benefit determination or NOA, and before the intended effective date of the adverse benefit determination being disputed, for the member to file an appeal. Standard appeals are processed within 30 calendar days. Expedited appeals are processed within 72 hours. The member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases.

To request a State Hearing: A state hearing is a way to solve problems where members, or an authorized representative acting on behalf of a member, can present their case to the state. To ask for a state hearing, call the California Department of Social Services toll free at 1-800-952-5253 (TTY users call 1-800-952-8349), or write to them at:

California Department of Social Services State Hearings Division
P.O. Box 944243
Mail Station 9-17-37
Sacramento, CA 94244-2430

Members, or an authorized representative acting on behalf of a member, have 120 days to ask for a state hearing from the date the member became unhappy. One can ask for a state hearing at any time during this 120-day period, including before, during, or after the member files a grievance. Once the judge decides the case, the member cannot ask for binding arbitration. If the member asks for a state hearing, the member may not be able to get an independent medical review later.

Faster (Expedited) Process: Members, or an authorized representative acting on behalf of a member, can ask the state to decide their state hearing request faster if it involves imminent and serious threat to the member's health, such as severe pain or potential loss of life, limb, or major body function. To ask for a faster decision, a member or their authorized representative may call the California Department of Social Services toll free at 1-800-952-5253 (TTY users call 1-800-952-8349), or write to them at:

California Department of Social Services
Expedited Hearings Unit State Hearings Division
P.O. Box 944243
Mail Station 9-17-37
Sacramento, CA 94244-2430

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).[26]

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. [27]

Overpayments

DHCS regulation requires that providers notify KP when they have received an overpayment, to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify in writing of the reason for the overpayment. Please report overpayments to KP within the required timeframe by calling Regional Claims Recovery at 1-844-412-0917.

Pharmaceutical Management

As of January 1, 2022, outpatient prescriptions drugs will be covered by Medi-Cal Rx through Fee-for-Service Medi-Cal, which is managed by Magellan Medicaid Administration. Medi-Cal members may access medications at any Medi-Cal FFS pharmacy provider. Clinic-administered drugs that are provided to patients during inpatient stays, clinic encounters, home health visits, or part of long-term care will still be covered by KP. KP will also 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.[28]

Grievances related to Medi-Cal Rx prescriptions should be submitted to Magellan's Medi-Cal Rx Customer Service Center (CS) starting January 1, 2022. Members can submit a complaint either in writing or by telephone by

going to www.Medi-CalRx.dhcs.ca.gov or calling Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. For clinic-administered drugs or prescription items covered by KP under state law, members will continue to submit grievances to KP.

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 Enrollment

New federal and state requirements mandate that managed care plan providers be enrolled in Medi-Cal in order to render services to KP Medi-Cal Managed Care Plan members. KP is utilizing the DHCS enrollment process for providers that are not already enrolled as a Medi-Cal provider. Per federal regulation, providers enrolled solely for the purpose of participation in a Medi-Cal managed care plan's network are not required to render services to Medi-Cal Fee-For Service members.

Provider Grievances

Providers may file a grievance for any issue. Grievances must be submitted orally or in writing within 180 days of the incident resulting in dissatisfaction. For assistance, please contact KP's Member Service Contact Center at 1-800-464-4000.

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.[29]

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.[30]

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.[31]

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.[32] 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 member's electronic medical record. 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.[33]

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.[34]

- 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 SCAL Regional Transportation HUB at 1-877-227-8799 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

Utilization Management (UM) 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. 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 medically 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 KP plan doctor or KP 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.

References

[1] MMCD APL 16-015
[2] MMCD APL 18-022
[3] MMCD APL 17-018
[4] MMCD APL 18-014
[5] MMCD APL 19-014
[6] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 9
[7] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 8
[8] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 12
[9] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 10
[10] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 11
[11] MMCD APL 18-012
[12] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 14
[13] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 15
[14] DHCS Contract Boilerplate, Exhibit A, Attachment 11, Section 17
[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] MMCD APL 18-014
[19] DHCS Contract Boilerplate, Exhibit G
[20] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 13.D; MMCD APL 17-011
[21] DHCS Contract Boilerplate, Exhibit E, Attachment 2, Section 25.B.1
[22] DHCS Contract Boilerplate, Exhibit A, Attachment 10, Section 8.A
[23] DHCS Contract Boilerplate, Exhibit A, Attachment 10, Section 3, MMCD PL 13-001
[24] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 14; Health & Safety Code Section 1367.04
[25] DHCS Contract Boilerplate, Exhibit A, Attachment 1, Section 5
[26] DHCS Contract Boilerplate, Exhibit A, Attachment 13, Section 1
[27] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9
[28] DHCS Contract Boilerplate, Exhibit A, Attachment 10, Section 8.G.3
[29] DHCS Contract Boilerplate, Exhibit A, Attachment 8, Section 15; MMCD APL 17-009
[30] MMCD APL 16-001
[31] DHCS Contract Boilerplate, Exhibit A, Attachment 7, Section 8
[32] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9
[33] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9.A; Title 22 CCR Sections 51305.1 & 51305.3
[34] MMCD APL 17-010 (Revised)