2023 Northern California Medi-Cal Provider Manual Supplement
Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members

2	Executive Summary and Medi-Cal Program Overview	8	Early Periodic Screening, Diagnosis, and Treatment Programs (EPSDT)	12	Provider Directory
3	Acupuncture	8	Health Education	13	Provider Enrollment
3	Alternative Birthing Centers, Certified Nurse Midwives, and Licensed Midwives; Doula Services	8	Language Assistance / Interpreter Services	13	Provider Grievances
3	California Advancing and Innovating Medi-Cal (CalAIM)	8	Managed Long-Term Services and Supports (MLTSS)	13	Provider Preventable Conditions
3	Care Coordination	9	Mandatory Managed Care Enrollment (MMCE)	13	Provider Suspension, Termination, or Decertification
6	Chiropractic Benefits	10	Medical Decisions	14	Punitive Action Prohibitions
7	Confidentiality and Protection of Privacy	10	Member/Provider Complaints, Grievances & Appeals	14	Sensitive Services
7	Continuity of Care (COC)	10	Member Rights and Responsibilities	14	Sterilization
7	Cultural Competency / Sensitivity Training	11	Minor Consent Services	15	Transportation / Travel and Lodging
8	Durable Medical Equipment Coverage	11	Pharmaceutical Management	15	Utilization Management (UM)
8	Fraud, Waste, and Abuse	12	Primary Care Physician (PCP) Assignment	16	Vision Benefits

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

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

KAISER PERMANENTE®

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 health care services for low-income individuals including families with children, seniors, persons with disabilities, and pregnant women. Medi-Cal is financed by both 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.

Across California, Medi-Cal accounts for approximately 10% 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, also referred to as Medi-Cal Managed Care (MMC) members throughout the remainder of this document, receive KP membership cards which are identical to other KP membership cards.

Kaiser Foundation Health Plan (KFHP) contracts directly with the Department of Healthcare Services (DHCS) for our Geographic Managed Care (GMC) Sacramento program. KFHP also contracts with Medi-Cal Managed Care Plan Partners (Table 1) to provide or arrange for the provision of services for Medi-Cal beneficiaries through The Permanente Medical Group, Inc. (TPMG), Kaiser Foundation Hospitals (KFH), and other contracted providers external to KP where necessary.

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)	• Dublin • Fremont Medical Center • Livermore Medical Offices • Oakland Medical Center	• Pleasanton Medical Offices • San Leandro Medical Center • Union City	Alameda
Contra Costa Health Plan (CCHP)	• Antioch Medical Center • Martinez Medical offices • Park Shadelands • Pinole Medical Offices	• Richmond Medical Center • Walnut Creek	Contra Costa
Geographic Managed Care (GMC)	• Fair Oaks Medical Center • Folsom Medical Offices • Elk Grove Medical Offices • Lincoln Medical Offices • Point West Medical Offices • Rancho Cordova Medical Offices	• Roseville Medical Center • Sacramento Medical Center • So. Sacramento Medical Ctr.	Amador, El Dorado, Placer, and Sacramento
Partnership Health Plan of CA (PHC)	• Davis • Fairfield, • Napa • Petaluma • Richard Stein (Santa Rosa)	• Rohnert Park • San Rafael • Santa Rosa • Vacaville • Vallejo	Marin, Napa, Solano, Sonoma, Yolo
Santa Clara Family Health Plan (SCFHP)	• Campbell • Gilroy • Milpitas	• Mountain View • San Jose • Santa Clara	Santa Clara

San Francisco Health Plan (SFHP)	• San Francisco		San Francisco
Health Plan of San Joaquin (HPSJ)	• Manteca • Stockton	• Tracy	San Joaquin
Health Plan of San Mateo (HPSM)	• Daly City • Redwood City • San Bruno	• San Mateo • So. San Francisco	San Mateo

Operational instructions in this Medi-Cal Provider Manual Supplement specifically relate to MMC members. Capitalized terms used in this Medi-Cal Provider Manual Supplement may be defined within this Supplement or if not defined herein, will have the meanings given to them in your Agreement.

Acupuncture

All 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 can contact KP's contracted provider American Specialty Health (ASH) directly at 1-800-678-9133 (8 a.m. to 5 p.m. PST) or they can go on the website: www.ashlink.com for more information.

Alternative Birthing Centers, Certified Nurse Midwives, and Licensed Midwives; Doula Services

KP provides our MMC members with access to Comprehensive Perinatal Services Program-certified freestanding Alternative Birthing Centers, as well as services provided by Certified Nurse Midwives and Licensed Midwives and Doula services, if requested by the member.[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.

California Advancing and Innovating Medi-Cal (CalAIM)

➔ Enhanced Care Management

KP provides access to enhanced care management, which is person-centered care management provided to the highest-need MMC members, primarily through in-person engagement where enrollees live, seek care, and choose to access services. Please direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ Community Supports (also known as "In Lieu of Services")

KP Medi-Cal managed care plan partners with community-based organizations to offer Community Supports, such as housing supports and medically tailored meals, which will play a fundamental role in meeting enrollees' needs for health and health-related services that address social drivers of health. Please direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

Care Coordination

KP coordinates services for its MMC members, including referrals to community resources and other agencies, when appropriate. These services include, but are not limited to:

➔ Behavioral Health

KP provides timely access to Non-Specialty Mental Health Services for MMC members under the age of 21 and outpatient mental health services for adult MMC members with mild to moderate levels of mental health impairment.[3] Members may be managed by Primary Care Physicians within their scope of practice, or KP Behavioral Health, as appropriate. MMC members are referred by KP Behavioral Health to the local county Mental Health Plan[4] for specialty services, including inpatient and outpatient Specialty Mental Health Services[4] for members with moderate to severe mental health conditions, wraparound, and other Short-Doyle mental health services, and to the county programs for substance use disorder treatment services. KP Behavioral Health assesses MMC members' level of treatment need and refers to county programs based on clinical necessity. Members living in Sacramento and Solano Counties may receive Specialty and Non-Specialty Mental Health Services directly through KP Behavioral Health. The referral process to county behavioral health programs may vary by county. For additional information, contact the KP Behavioral Health Department for assistance at 1-800-390-3503 Monday through Friday, from 8 a.m. to 5 p.m. PST.

➔ Alcohol Misuse: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment

KP expects contracted Primary Care Physicians to screen MMC members ages 11 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 offers members with a behavioral counseling intervention. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling. KP ensures 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.[5]

➔ Behavioral Health Treatment (BHT) Services for Members Under the Age of 21

Behavioral Health Treatment (BHT), including Applied Behavioral Analysis (ABA) therapy are covered for MMC members under 21 years of age. The MMC 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.[3] For additional information, providers can contact the KP Behavioral Health Department for assistance at 1-800-390-3503 Monday through Friday, from 8 a.m. to 5 p.m. PST.

➔ Blood Lead Screening

In accordance with state and federal requirements, KP requires contracted Primary Care Physicians to screen children enrolled in Medi-Cal for elevated blood lead levels (BLL) as part of required prevention services offered through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. See "Early and Periodic Screening, Diagnosis, and Treatment" section for additional details on EPSDT.[6]

➔ California Children's Services

California Children's Services (CCS) is financially responsible for any services that are determined to be CCS-eligible. Any CCS eligible services should be billed to CCS before billing KP. If CCS determines there is no eligibility, include a copy of the CCS Notice of Action (NOA) when you bill us, or the claim will be denied. For tips on billing CCS, please refer to the DHCS Medi-Cal Provider website at: http://www.medi-cal.ca.gov

Whole Child Model (WCM) is carved out of CCS and not part of the above process. For specific details on CCS medical eligibility please visit: https://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." A CSHCN identified member receives a comprehensive assessment of health and related needs, including needed referrals for additional supports and services as applicable.[7] Please direct any member requests for the above listed services, to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ Coordination with Local Education Agency Services

KP collaborates with Local Education Agencies (LEAs) in the development of Individual Education Plans (IEPs) or Individual Family Service Plans for its MMC members.[8] Please direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ Developmental Disabilities

KP refers members with developmental disabilities to a Regional Center for evaluation.[9] The Association of Regional Center Agencies (ARCA) represents the community-based network of regional centers which provides lifelong services for individuals with developmental disabilities in California. 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. Please direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ Early Intervention Services/Early Start Program

KP identifies children who may be eligible for a referral to a local Early Start program to address developmental delays. KP covers/provides all medically necessary speech, occupational, and physical therapy services for MMC members with a developmental delay regardless of age.[10] 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 direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ HIV/AIDS

KP is responsible for the identification and referral of MMC 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 Physicians ensure 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. KP provides dental screenings during the Initial Health Appointment (IHA) and during periodic assessments for members under the age of 21. Members are referred to appropriate Medi-Cal dental providers, and for the provision of

covered medical services not provided by dentists or dental anesthetists. Please refer the patient to their Primary Care Physician for further assistance.[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 five (5) years of age to eat well and stay healthy. KP is responsible for the referral of MMC 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] Please direct any member requests for the above listed services to their Ob/GYN or Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

➔ Major Organ Transplant Services

Effective January 1, 2022, major organ transplants became the responsibility of Medi-Cal managed care plans for all adult MMC members (21+ years of age) enrolled in a plan.[14] Pediatric members who are referred to CCS-approved transplant Centers of Excellence (COEs) will require a CCS Service Authorization Request (SAR). KP is required to cover transplant and transplant-related services for its MMC members who are enrolled in a GMC contract or with any limited license Medi-Cal managed care plan (MCP) which contracts with KP where transplant services have been delegated to KP. KP contracts with COEs for its transplant network. A COE is a transplant center that has received DHCS designation to confirm that the transplant unit within the hospital meets DHCS' criteria for a transplant program. Providers or their clinic staff should contact the Transplant HUB at 888-551-2740 for additional details or care coordination needs.

Chiropractic Benefits

Medi-Cal beneficiaries may have coverage for chiropractic services regardless of which Medi-Cal contract they are enrolled in.[15] They include the following groups:

- Children under age 21
- Pregnant women through the postpartum period
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

KP MMC members under 21 years of age, pregnant mothers, and members residing in a skilled nursing facility, intermediate care facility, or subacute care facility are able to contact KP's contacted provider, American Specialty Health (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

Covered chiropractic services are limited to manual manipulation of the spine for up to two visits per calendar month. ASH shall manage medical necessity beyond the two visits per calendar month requirement. Please note that coverage does not include chiropractic appliances.

Note: Chiropractic services are covered for MMC members of all ages when received at county hospital outpatient departments, county outpatient clinics, at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) that are in Kaiser Permanente's network. FQHCs or RHCs may require a referral. Not all county facilities, FQHCs or RHCs offer outpatient chiropractic services. MMC members requesting chiropractic services at any of the above-mentioned facilities are encouraged to contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

Confidentiality and Protection of Privacy

All providers with whom KP contracts are subject to state and federal 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 KP's Compliance Hotline at 1-888-774-9100.

Continuity of Care (COC)

Continuity of Care with current providers may be required when MMC members move to another plan pursuant to Health and Safety Code Section 1373.96. 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 DHCS. 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 Member Services Call Center at (800) 464-4000 and request a copy of the KP completion of Covered Services policy.

Cultural Competency / Sensitivity Training

KP ensures that all medically necessary covered services are available and accessible to all MMC 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.[16]

California and Federal laws require that KP provides Limited English Proficient members with 24/7 access to qualified language assistance services. Onsite and telephone or video interpreters are available. For more information, please see the Provider Manual for HMO Members. It can be located by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

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.

DHCS requires that KP, as a Medi-Cal Managed Care Plan, provide cultural competency, sensitivity, or diversity training for its contracted providers at key points of contact for KP members, such as reception

staff and direct caregivers.[17] This training helps reinforce KP's commitment to effectively deliver health care services in a culturally competent manner that meets the social, cultural, and linguistic needs of our members. To obtain an electronic copy of this training to disseminate to staff, please visit the Kaiser Permanente Community Provider Portal at: http://kp.org/providers/ncal

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 chairs, and some types of wheelchairs. Prior Authorization is required for DME. For further information on ordering DME, please contact the Member Services Call Center at (800) 464-4000.

Fraud, Waste, and Abuse

Please see the Provider Manual for HMO Members. It can be located by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

Early Periodic Screening, Diagnosis, and Treatment Programs (EPSDT)

Under the EPSDT program, KP provides comprehensive screening including Blood Lead 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, behavioral health, diagnostic services, treatment, and services 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.[17] Please direct any member requests for the above listed services to their Primary Care Physician. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

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.[18] 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. For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

Language Assistance / Interpreter Services

Please see the Provider Manual for HMO Members. It can be located by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

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. Please contact your local KP Care Coordination Team for further support. Sacramento County/Central Valley area: 1-833-721-6012

(TTY 711), Monday through Friday, 8 a.m. to 5:30 p.m. All other Northern California service areas: 1-833-843-6363.

➔ 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 MMC members who meet medical necessity criteria. Members may attend one to five days per week, and transportation to and from home is provided. To inquire about CBAS for KP members of KP's GMC Sacramento region or those assigned to KP through Alameda Alliance for Health or Health Plan of San Joaquin, contact the Medi-Cal Clinical Decision Unit at 1-866-842-2574. For other MMC members, refer members to their respective plan partner.

➔ Long Term Care

For Managed Medi-Cal members, Long Term Care (LTC) includes admission to an intermediate, skilled, or sub-acute care facility, extending to the month following admission if members meet Medi-Cal clinical criteria. Depending upon the county, the care may continue to be managed and paid by KP following the month after admission. Coordination and/or payment for LTC is either by a managed care plan or DHCS fee-for-service, depending on the county and level of care needed.

➔ Multi-purpose Senior Support Programs

Multi-purpose Senior Support Programs (MSSP) provide care management and coordinate community services for MMC 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 providers may advise members in need of MSSP to contact their local MSSP office for assistance. Please direct any member requests for the above listed services to their Primary Care Physician.

➔ In Home Support Services

In Home Support Services (IHSS) are for MMC 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 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 IHSS is either by the managed care plan or the county; payment is by the county. Primary Care Physicians may advise members in need of IHSS to contact their local IHSS office for assistance. Please direct any member requests for the above listed services to their Primary Care Physician.

Mandatory Managed Care Enrollment (MMCE)

The purpose of this notice is to announce changes that will affect dually eligible members (members enrolled in both Medicare and Medi-Cal). Effective January 1, 2023, dually eligible Medicare and Medi-Cal beneficiaries and institutional long-term care populations will transition to managed care enrollment, except for individuals eligible for disenrollment or exemption from mandatory enrollment.[14]

If there is a need to verify benefits and eligibility, please refer to the Online Affiliate tool by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

Medical Decisions

KP must ensure that medical decisions, including those by TPMG and KFH contractors and rendering providers, are not unduly influenced by fiscal and administrative management.[19] 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 available online at https://thrive.kaiserpermanente.org/medicaid/medi-cal-california/new-members#handbook

For additional information, providers can contact KP's Member Services Call Center at 1-800-464-4000 for assistance.

Member Rights and Responsibilities

MMC 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, including Covered 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 care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services, and Emergency Services outside KP's network pursuant to federal law.
- To request a State Hearing, including information on the circumstances under which an expedited State Hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend, or correct their medical record.
- To disenroll upon request. Beneficiaries who can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs, and members with special health care needs.
- To change Medi-Cal Managed Care Health Plans upon request.
- 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 a timely fashion appropriate for the format being requested and in accordance with W & I 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.
- To receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- 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).[20]

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 KP Member Services. Please refer to the Provider Manual for HMO Members for more information on filing a grievance. The Provider Manual for HMO Members can be located by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

A complaint (or grievance) is when a member has a problem with KP or a provider, or with the health care or treatment the member received from a provider. An appeal is when the member doesn't agree with KP's decision not to cover or to change the member's services.

Minor Consent Services

Under California law, members under the age of 18 can see a doctor without consent from their parents or guardian for the following types of care. 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 (except sterilization)
- 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, sexual or physical abuse.[21]

Pharmaceutical Management

Outpatient prescriptions drugs are 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.[22] KP is no longer managing the formulary applicable to MMC members. The DHCS Drug Formulary, now called the Contract Drug List, can be accessed using the following link: https://medi-calrx.dhcs.ca.gov/home/cdl/

In long-term care, Medi-Cal pharmacy services billed on a medical or institutional claim by a pharmacy, or any other provider, must be billed through KP. If prescription drugs are not part of the bundled rate for services provided by a skilled nursing facility, and instead are billed on a fee for service basis, then the financial responsibility for those drugs is determined by the claim type on which they are billed. If the drugs are dispensed by a pharmacy, and billed on a pharmacy claim, then they are carved out and paid by Medi-Cal RX. If the drugs are furnished by the skilled nursing facility and billed on a medical or institutional claim, then KP is responsible. Per Long Term Care Benefit APL.

Additional information related to drug coverage can be found by visiting: https://medi-calrx.dhcs.ca.gov/home/

Clinic-administered drugs that are provided to patients during inpatient stays, clinic encounters, home health visits, or as 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.

Grievances related to Medi-Cal Rx prescriptions should be submitted to Magellan's Medi-Cal Rx Customer Service Center (CS). 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. Please see Member/Provider Complaints, Grievances & Appeals section above for more information on how to submit a grievance 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.[23] 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. Contracted PCPs should work within established KP protocols to coordinate specialty care.

Examples of Specialists that require a referral include:

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

Provider Directory

KP must include the following information in our provider directory for all contracted providers:[24]

- The provider's name as well as any group affiliation
- Address(es)
- Telephone number(s)
- Web site URL, as appropriate
- Specialty, as appropriate

- Whether the provider will accept new enrollees
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment
- PCP number (plan assigned, alpha/numeric up to 15 digits total)
- Primary Care Clinic or Medical Group/Independent Practice Association name (example: Eastside Clinic).
- Office hours
- Languages (other than English) spoken at provider site

Provider Enrollment

Federal and state requirements mandate that managed care plan providers recognized by DHCS as eligible to enroll be enrolled in Medi-Cal in order to render services to KP Medi-Cal Managed Care Plan members.[25] Most providers enroll in Medi-Cal through the DHCS enrollment unit. Alternately, some MMC plans maintain Medi-Cal enrollment units to enroll providers solely for the purpose of participating in the MMC plan's network. Providers enrolled through a MMC plan enrollment unit are recognized by other MMC plans as enrolled for the purpose of participation in the network of the other MMC plan's network as well. Per federal regulation, providers enrolled solely for the purpose of participation in a MMC plan's network are not required to render services to Medi-Cal Fee-For Service members. KP does not maintain a MMC plan enrollment unit.

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 Services Call 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 MMC member by that provider. DHCS requires KFHP to report PPCs that are associated with claims for Medi-Cal payment (FFS or by a MMC plan) or for courses of PPC treatment prescribed to a MMC 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.[26]

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.[27]

KP may terminate its contract with a Network Provider/Subcontractor and/or suspend payments to a Network Provider/Subcontractor in accordance with DHCS requirements.

For all terminations, KP must mail appropriate member notifications and remain accountable for all functions and responsibilities of the terminated Network Provider/Subcontractor to ensure that impacted members do

not experience disruption in access to care. If a contract is successfully renegotiated with a Network Provider/Subcontractor before the effective date of the contract termination, and member notices were already mailed out, KP must mail another notice to inform members that the contract is not being terminated.

Punitive Action Prohibitions

KP may not take punitive action against a provider who either requests an expedited resolution or supports a MMC 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 MMC 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.[28]

Sensitive Services

Sensitive services are defined as all health care services related to:

- Mental or behavioral health
- Sexual and reproductive health
- Sexually transmitted infections
- Substance use disorder
- Gender affirming care, and
- Intimate partner violence

Sensitive services include services described in Sections 6924—6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services. If a member requires assistance, please refer them to their care coordination team or Primary Care Physician for support and care. Some services may be accessed in the community and our community partners will collaborate with applicable KP providers for coordination of care.

Sterilization

California law requires that MMC 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. The form can be located by visiting the following site: https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf

KP has internal processes for the completion of the PM 330 form. Please refer the patient to their Primary Care Physician for further assistance.

MMC members may not waive the 30-day waiting period for sterilization.[29]

Transportation / Travel and Lodging

In addition to emergency medical and non-emergency ground/air ambulance, KP covers non-emergent medical transportation (NEMT), and non-medical transportation (NMT) for KP-Assigned MMC members and travel and lodging.[30]

- NEMT: Available to MMC members requiring transportation to covered medical services (including pharmacy), but for whom traditional means of private or public transportation is medically contraindicated due to the member's medical or physical condition. Contact KP's NCAL Regional Transportation HUB at 1-800-438-7404 for assistance. NEMT services must be authorized by KP, and the member must be a KP-assigned MMC member, have no other way to get to their scheduled appointment or service and be unable to reasonably ambulate or unable to stand or walk without assistance.
- NMT: Available to all MMC members requiring round-trip transportation to a covered medical appointment or service, including pharmacy. Unlike NEMT, clinical authorization/medical necessity by the member's provider is not required. NMT services are available for KP-MMC assigned members when the member has no other way to get to their scheduled appointment or service and when the member is able to ambulate without help from the driver. Providers or their staff may direct the MMC member to call KP Transportation Services at 1-844-299-6230, TTY services dial 711.
- Travel and Lodging: Covered for MMC members who are referred to medically necessary services that are not available within a reasonable distance from a member's home such that the member is unable to make the trip within a reasonable time. For general questions regarding travel and lodging or to request the reimbursement form, please call the travel and lodging coordinator at (510) 987-4650 or visit: kp.org/specialty-care/travel-reimbursements

MMC members may also contact the Member Services Call Center at 1-800-464-4000 for assistance with questions regarding NEMT, NMT or travel/lodging benefits.

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 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.

For more details, please see the Provider Manual for HMO Members. It can be located by visiting the KP Community Provider Portal at: http://kp.org/providers/ncal

Vision Benefits

➔ Eye Exams

Members are covered for eye exams to determine if they need eyeglasses and to provide a prescription for eyeglasses.[31] Please direct any member requests for the above listed services, to KP's Member Services Call Center at 1-800-464-4000 for scheduling assistance.

➔ 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 Evidence of Coverage for additional 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 a member's contact lenses are lost or stolen.

References

[1] MMCD APL 16-015 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-015.pdf
[2] MMCD APL 18-022 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-022.pdf
[3] MMCD APL 22-006 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf
[4] BHIN 22-026 available at:
https://www.dhcs.ca.gov/Documents/BHIN-22-016-Authorization-of-Outpatient-Specialty-Mental-Health-Services.pdf
[5] MMCD APL 21-014 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf
[6] MMCD APL 20-016 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf
[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] 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] MMCD APL 21-015 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf
[15] MMCD APL 15-003 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-003.pdf
[16] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 13.D; MMCD APL 17-011
[17] MMCD APL 19-010 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf
[18] MMCD APL 18-016 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-016.pdf
[19] DHCS Contract Boilerplate, Exhibit A, Attachment 1, Section 5
[20] DHCS Contract Boilerplate, Exhibit A, Attachment 13, Section 1
[21] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9
[22] Executive Order N-01-19 (Medi-Cal RX) available at:
https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf
[23] DHCS Contract Boilerplate, Exhibit A, Attachment 13, Section 7
[24] CMS MegaReg: 1342 C.F.R. § 438.10(h) and MMCD APL 19-003 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-003.pdf
[25] MMCD APL 22-013 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-013.pdf
[26] DHCS Contract Boilerplate, Exhibit A, Attachment 8, Section 15; MMCD APL 17-009
[27] MMCD APL 21-003 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-003.pdf
[28] DHCS Contract Boilerplate, Exhibit A, Attachment 7, Section 8
[29] DHCS Contract Boilerplate, Exhibit A, Attachment 9, Section 9.A; Title 22 CCR Sections 51305.1 & 51305.3
[30] MMCD APL 22-008 available at:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf
[31] DHCS Contract Boilerplate, Exhibit A, Attachment 10, Section 14.D