KPGA Network News: E-Edition

Kaiser Permanente of Georgia Earns Medicare 5 Star Rating

ALL 2022 KAISER PERMANENTE MEDICARE HEALTH PLANS EARNED 5 STARS FOR EXCELLENT CARE AND MEMBER EXPERIENCE.

Kaiser Permanente has star power. The Medicare health plan in every region we serve has received a 5-star rating — the highest possible — from the Centers for Medicare & Medicaid Services for 2022.

CMS' Medicare Part C (health plan) and Part D (drug plan) Star Rating system is designed to allow Medicare-eligible individuals to compare Medicare health plans based on quality and performance. Plans that receive 5 out of 5 stars in the annual ratings are recognized as excellent, providing expert medicine, seamless care, and outstanding service to their Medicare health plan members.

Our 2022 plans in California, Colorado, Georgia, Hawaii, the mid-Atlantic states (Maryland, Virginia, and Washington, D.C.), the Northwest (Oregon and Southwest Washington), and Washington state all received 5 out of 5 stars.

"These ratings affirm our standing as one of the finest health care organizations in the country and represent the excellent care provided by our highly skilled physicians, nurses, clinicians, and front-line staff," said Nancy Gin, MD, executive vice president and chief quality officer for The Permanente Federation, the national umbrella organization for the more than 23,000 physicians who provide care to Kaiser Permanente's members. "We are dedicated to providing high-quality care for our Medicare health plan members and helping them live full, active lives."

CONSISTENTLY A TOP CHOICE

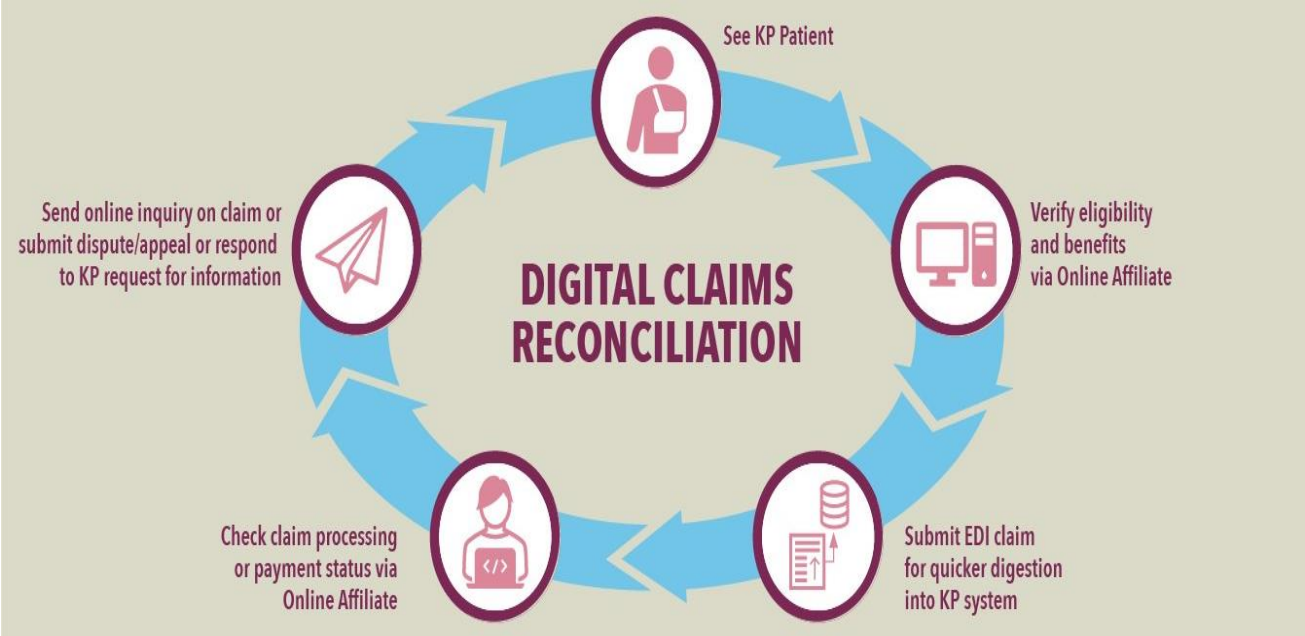
Kaiser Permanente first earned the distinction of 5-star ratings for all of its Medicare health plans in 2014. This is also the 11th consecutive year all Kaiser Permanente Medicare health plans have been rated 4.5 stars or higher. Kaiser Permanente provides care to nearly 1.8 million Medicare health plan members in 8 states and the District of Columbia.

"Kaiser Permanente is proud to provide, year after year, the highest quality health care and service, which is what our Medicare health plan members expect and deserve," said Andrew Bindman, MD, executive vice president and chief medical officer for Kaiser Permanente. "From the moment our Medicare health plan members choose Kaiser Permanente for their care and coverage, we work diligently to provide an exceptional, coordinated care experience, and this distinction is a reflection of those efforts."

Every year, CMS rates all Medicare Advantage health plans (Parts C and D) on multiple facets of care and service, including chronic conditions management, health maintenance, patient experience, customer service, and pharmacy services. Kaiser Permanente's excellent plan ratings demonstrate the value of our integrated health care delivery system, which brings myriad services together, in many cases all under one roof, and puts our patients at the center of care.

Reminder: **Please use Online Affiliate for claims, appeals, disputes, inquiries, EOPs, responding to requests for information (RFI), and uploading claims supporting documents. Please do not use faxes for provider appeals and disputes.**

PROVIDER DIGITAL TOOLS



Get paid faster!
Reduce costs and save time with self-service tools!

Online Affiliate is Kaiser Permanente's online provider portal, equipping external providers with many time-saving features such as viewing patient benefits, eligibility, and demographics. You can check the status of claims, and view and print Explanation of Payment (EOP) statements.

Now, you can even "Take Action" on claims and submit inquiries to get more information on 'in progress" or denied claims," as well as submit disputes, appeals, or respond to KP requests for information.

Enroll with **electronic data interchange (EDI)** or Office Ally Direct Data Entry for easier and quicker claim creation. To sign up, contact your clearinghouse and provide the appropriate payor ID from the table below:

Accepted Clearinghouse	Payor ID
ChangeHealthcare (CHC)	21313
Navicure	21313
Office Ally	21313
SSI	21313
OptimumInsight/Ingenix	NG010**
Relay Health	RH008

To register for **Online Affiliate** or learn more about **electronic claim submissions**, please visit providers.kp.org/ga and select the Online Affiliate link.

Special Needs Plans (SNP)

Kaiser Permanente of Georgia (KP) offers a Special Needs Plan (D-SNP), the Senior Advantage Medicare- Medicaid Plan, for its dual eligible members who have both Medicare and Medicaid. Dually eligible persons tend to have complex medical and psychosocial needs.

The Centers for Medicare & Medicaid Services' goal for all Special Needs Plans is to improve member health outcomes by ensuring: 1) Improved access to medical, mental health and social services; 2) Better coordination of care; 3) Adequate provider network; 4) Seamless transition of care through an identified point of contact; 5) Appropriate utilization of services; 6) Cost-effective service delivery.

The SNP Model of Care (MOC) Elements include:

1) **Description of the SNP Population**: The SNP MOC describes its population demographics and unique characteristics of the most vulnerable members, including but not limited to:
   - Age, gender, and ethnicity
   - Socioeconomic status, living conditions and environmental factors
   - Barriers, such as language and other significant barriers
   - Major diseases, co-morbidities, chronic conditions
   - Social, cognitive, and functional limitations
   - As of 01/01/2021 KFHP-GA has 1130 SNP members.
     - 70% of SNP members are female. The average age is 70 (69.9) with 5% of members at age 65 and older.
     - The SNP population is racially and ethnically diverse. African Americans represent most beneficiaries at 53.8%.
     - SNP members speak over 31 different languages; English is the most commonly spoken primary language.

2) **Care Coordination**: The SNP MOC details key roles and responsibilities of the care coordination process including a comprehensive assessment, referring and facilitating health care and community-based services, development and implementation of a person-centered care plan, monitoring and follow up. Care coordination responsibilities for SNP care managers include, but are not limited to:
   - **Completing Health Risk Assessment (HRA)**: SNP care managers are required to conduct an HRA of the SNP member upon initial enrollment (within 90 days before or after a SNP member's current effective enrollment date), annually (within 365 days of last assessment), and when members experience a significant change in health. The HRA assesses the status of the member's medical, functional, mental health, cognitive, and psychosocial status and needs.
   - **Development of an Individual Care Plan (ICP)**: Based on the HRA results and member's input, SNP care managers develop a care plan that includes goals (including member's goals); interventions, preferences and values are incorporated for self-management. The care plans are routinely updated and routed to the member's PCP for review and follow up as appropriate.
   - **Collaboration of an Interdisciplinary Care Team (ICT)**: The ICT comprises multiple disciplines that include the primary care physician (PCP), nursing, social services, geriatric medicine, pharmacy, and behavioral health and includes the engagement of the member and/or caregiver as needed. The ICT supports the PCP to better manage the health needs of the SNP member.
   - **Seamless Care Transitions**: SNP care managers serve as the point of contact to coordinate seamless transitions across healthcare settings. In collaboration with providers, SNP care managers ensure the members and/or caregivers understand the discharge instructions. To prevent avoidable readmission, medications are reviewed, future appointments are discussed, barriers are identified, referrals to appropriate community-based services are made. The SNP ICP is updated and shared with the PCP.

3) **SNP Provider Network**: The SNP MOC describes KP as an integrated delivery system with clinical expertise and specialized care available to serve the SNP population. It describes how KP ensures the provider network completes mandatory trainings and maintains licensed and competent providers. The MOC describes the provider network's additional responsibilities that include but are not limited to:
   - The use and knowledge of KP approved clinical practice guidelines (CPG) and recommendations when providing care to SNP population; under certain circumstances and/or when CPG is unavailable, KP providers shall make decision based on clinical expertise.
   - Ensuring continuity of care when a care transition occurs.

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4) **MOC Quality Measurement & Performance Improvement**: The SNP MOC describes KP's overall quality measurement and improvement plan, which includes the following:
   - Identification of key stakeholders (i.e., SNP leadership, SNP personnel, and SNP provider networks)
   - How KP shares and communicates quality performance results with key stakeholders (i.e., SNP dashboards, Annual QI Workplan, and other ad hoc reports)
   - How the regional SNP leadership team continuously evaluates the performance of the Special Needs Plan against the model of care requirements.
   - Identification of specific outcome measures used to evaluate program and member outcomes and care effectiveness (i.e., select HEDIS measures such as Medication Review, Functional Status and Pain Screening, 30-Day Readmissions, and process measures)
   - Description of the methodology to measure member experience with the SNP program

For additional information, please contact Carole Gardner, MD, Physician Lead for SNP (carole.gardner@kp.org).

COVID-19 Vaccines

Reminder: For Medicare Advantage Members, there is no cost-sharing for Covid-19 Vaccines and administration, including booster shots.

HR 133-The No Surprises Act

SEC. 2799B–9. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PROVIDER BUSINESS PROCESSES. —Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer...

Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;
(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;
(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable; and
(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

Targeted Review List (QRM) Updates

All procedures on the Target Review List must be authorized prior to rendering services, or the procedure will not be covered. Please see http://providers.kp.org/ga for more information regarding the Target Review List.

Medications Requiring Prior Authorization

Kaiser Permanente periodically updates the QRM List of Medications following P&T meetings which occur on the even months (i.e. February, April, etc.) of the year. Please be sure to review the list carefully.

The QRM List of Medications (Targeted Review List) is on our Provider Website at http://providers.kp.org/ga. As a reminder, failure to obtain authorization prior to providing the medications listed will result in a denial of coverage. Please note affected members will be notified of this change.

New QRM Medications effective 9.9.2021:

- Fotivda (tivozanib)
- Lupkynis (voclosporin)
- Ponvory (ponesimod)

QRM Criteria Updates effective 9.9.2021

- CGRP Inhibitors
- GLP-1 Receptor Agonists
- Hepatitis C Virus Treatment (Epclusa, Mavyret, Vosevi, Harvoni)
- Interleukin Antagonists
- Nurtec ODT (rimegepant)
- Palforzia (peanut allergen powder)
- Saxenda (liraglutide)
- SGLT-2 Inhibitors (Jardiance and Farxiga)

Medicare Part D Benefit Coverage – Product Additions/Removals

During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List).

For product removals, affected members who were prescribed these drugs prior to each effective date will be grandfathered until the end of 2021, meaning members will continue to receive the removed product under their Part D benefit through 12/31/2021, except for members who have been converted to the generic alternatives.

Product Addition

Effective 7.7.2021:

TRULANCE 3 MG TABLETS (plecanatide) added to Preferred Brand Tier 3.

Product Removals

Effective 9.1.2021:

- Brand name: BEPREVE SOLUTION 1.5%
  - Alternative product available: generic BEPOTASTINE BESILATE SOLUTION 1.5% (added to Generic Tier 2)

Effective 10.1.2021:

- Brand name: INTELENCE TABLETS 100 MG and 200 MG
  - Alternative products available: generic ETRAVIRINE TABLETS 100 MG and 200 MG (added to Generic Tier 2)
- Brand name: KALETRA TABLETS 100-25 MG and 200-50 MG
  - Alternative products: generic LOPINAVIR-RITONAVIR TABLETS 100-25 MG and 200-50 MG (added to Generic Tier 2)
- Brand name: PERFOROMIST NEBULIZER SOLUTION 20 MCG/2ML
  - Alternative product: authorized generic FORMOTEROL FUMARATE NEBULIZER SOLUTION 20 MCG/2ML (added to Non-Preferred Brand Tier 4)
- Brand name: SOOLANTRA CREAM 1 %
  - Alternative product: generic IVERMECTIN CREAM 1 % (added to Generic Tier 2)

Provider Manual Changes For 2022

Please refer to the 2022 Provider Manual that is posted on Online Affiliate, accessible from http://providers.kp.org/ga, to review all changes and determine impact to your practice.

Section 1&2:
- 1.4.3 Kaiser Permanente Medical Offices
- 1.4.8 KPGA Radiology Services
- 1.4.10 Interventional Radiology
- 1.5 Self-Funded: KPIC
- 2.1 Fully Funded: Key Contacts
- 2.2 Self-Funded: Key Contacts
- 2.3 Self-Funded: Customer Service IVR
- 2.4 Self-Funded Website
- 2.5 Self-Funded Glossary

Section 3:
- 3.1 Member's Eligibility and Covered Benefit Verifications
- 3.1.1 Fully Funded Benefits and Eligibility Verifications
- 3.1.2 Self-Funded Member Benefits and Eligibility Verifications
- 3.4.1 Self-Funded Benefit Exclusions and Limitations
- 3.9 Special Needs Plan (SNP) Members
- 3.10.3 Self-Funded Pharmacy Benefits
- 3.10.5 Criteria Restricted Prior Authorization Medications
- 3.10.6 Removed: Type 2 Diabetes Drugs

Section 4:
- 4.1 Decision Making for Medical Service Requests
- 4.2 Concurrent Review Process
- 4.3 Medical Necessity Criteria
- 4.4 Referral and Authorization
- 4.6 Preauthorization Policy and Procedure
- 4.6.1 Authorization Limitations and Expiration
- 4.7 Kaiser Permanente Targeted Review List
- 4.7.1 Durable Medical Equipment (DME)
- 4.7.2 Emergency Services
- 4.7.4 Scheduled or Elective Inpatient Admission and Services
- 4.7.6 Home Health/Hospice Services
- 4.8 Request for Non-Contracted Provider Authorization
- 4.12 Case and Care Management
- 4.13.1 Kaiser Permanente's Complete Care Programs
- 4.15 Drug Formulary
- 4.16.2 Step Therapy Medication Authorization Process
- 4.18 Self-Funded Grievances and Appeals
- 4.18.1 Self-Funded Member Appeals
- 4.19.1 Self-Funded Expedited Appeals

Section 5:
- 5.1 Fully-Funded: Contact Information
- 5.2 Self-Funded: Contact Information
- 5.14 Supporting Documentation
- 5.17 Electronic Data Interchange (EDI)
- 5.17.2 Fully-Funded: EDI Submissions
- 5.19.1 EDI Claim Forms: 837P (Professional) Guidelines
- 5.19.2 EDI Claim Forms: 837I (Institutional) Guidelines
- 5.23.1 Fully-Funded: Electronic Funds Transfer (EFT) Payment
- 5.24 HIPAA Requirements
- 5.31 Self-Funded: Claim Adjustments/Corrections (Retrospective or Otherwise)
- 5.33 Self-Funded: Incorrect Claims Payments
- 5.36 Member Cost Share
- 5.37 Member Claims Inquiries
- 5.38 Visiting Members
- 5.40 Coding Standards
- 5.43 Fully Funded: Coding & Billing Validation
- 5.48 Clinical Review
- 5.49 Third Party Liability (TPL)
- 5.50 Workers' Compensation
- 5.51 First Party Liability
- 5.53.2 Self-Funded Claims Disputes
- 5.58.1 Capitation Payments
- 5.58.10 Surgery
- 5.59.1 How to Determine the Primary Payor

Section 6:
- 6.1.2 Changing PCPs
- 6.10 Fully Funded: Claims Appeal Process
- 6.11 Self-Funded: Claims Appeal Process
- 6.12 Complaints/Grievances Between Members and Providers

Section 7: No changes

Section 8:
- 8.4.1 Credentialing and Recredentialing Process

Section 9: No changes

Referrals and Authorizations

For all services that require a referral or authorizations you must have a valid referral/authorization prior to providing services.

If a referral/authorization is not received prior to rendering services, your claim will be denied, and the member will be held harmless.

Kaiser Permanente will not provide retro referrals/authorizations. Please refer to the provider manual for additional information.

Fee Schedule Updates

It is the policy of Kaiser Permanente of Georgia's Provider Contracting and Network Management Department (PC&NM) to review and update the fee schedules annually. The 2022 RBRVS updates to the will be effective 45 days from the release of the CMS fee schedule components. Updates to the Kaiser Permanente Market Fee Schedule will be effective April 1st. A copy of the KPMFS schedule is posted on Online Affiliate, which you can access from www.providers.kp.org/ga.

Have you verified your demographic information?

Federal law mandates that we verify your demographic information quarterly. Please send responses and rosters in a timely manner for all verification requests and outreach.

- Do our members know how to get to or contact your office?
- Are we able to make accurate referrals?
- Have you checked to make sure your Network Manager has all of the correct information regarding your practice and group members?
- Have you sent an updated roster?
- Have you responded to Credentialing questions or requests for new documentation?
- Have you responded to quarterly directory verification or outreach?

Please feel free to contact us if you think any of your information may be incorrect. You can reach out to your Network Manager: Dereck, Domonique, or Roderick directly or you can email Provider Contracting at ga.provider-relations@kp.org.

If you know any of your demographics are changing, or have changed, please let Provider Contracting know at least 60 days in advance, or as soon as possible.

Please contact us at with any changes ga.provider-relations@kp.org.

ga.provider-relations@kp.org (404)-364-4934