KAISER PERMANENTE®

October 2024

Re: Annual National Committee for Quality Assurance (NCQA) Update for Year 2025

Kaiser Permanente (KP) would like to take this opportunity to communicate and reaffirm our longstanding policies regarding open member-practitioner communication, protection of Members' confidentiality and privacy, access and availability, access to care decisions, medical record expectations, and other aspects of our Quality and Utilization Management/Resource Management Programs.

Non-discrimination and Member-Practitioner Communication

A basic value of KP is that members and patients are treated with sensitivity, dignity, and respect while receiving quality care.

Kaiser Permanente follows State and Federal civil rights laws, including but not limited to Section 1557 of the Affordable Care Act (Section 1557) and the laws referenced therein. Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

All employees, physicians, and contractors are required to comply with KP's enterprise-wide Non-Discrimination, Equal Access to Facilities, Services, and Programs, and Service Animal policies, which memorialize our commitment to these civil rights protections.

Everyone deserves access to care that is equitable and inclusive. Effective communication is the foundation of quality care, so Kaiser Permanente provides access to language and other auxiliary aids and services free of charge, 24 hours a day, seven days a week, including, but not limited to:

- Qualified interpreters, including sign language interpreters
- Written information in languages other than English and in alternative formats (braille, large print, audio, accessible electronic formats, and other formats)
- Other auxiliary aids or services as appropriate to the encounter type and nature of the communication.

Kaiser Permanente facilities, technology, and medical and diagnostic devices and services must be accessible to individuals with disabilities in accordance with the latest state and federal accessibility guidelines and standards. All employees, physicians, and contractors are also required to reasonably modify any standard policies, practices, and procedures as needed to make care and services fully accessible to individuals with disabilities, in accordance with Section 1557 and other federal and state nondiscrimination laws.

We believe that quality of health care includes a full and open discussion with each patient regarding all aspects of medical care and treatment alternatives, without regard to benefit coverage limitations, while maintaining confidentiality consistent with the confidentiality policies set forth by KP. Conforming to these long-standing values, KP allows open Member-Practitioner communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing all available care options with all Members.

Confidentiality Privacy and Security Policy Statement

KP maintains policies regarding the confidentiality, privacy, and security of member-identifiable information including policies related to access to protected health information (PHI), protection of PHI in all settings, the use of data for quality management, and disclosure of information to Members' employers, PHI may be in “oral, written, or electronic form”. KP’s workforce (employees, physicians, volunteers, trainees, or other persons who work for KP, or work on its premises, and are under its control, even if another organization pays them) is required to maintain the confidentiality, privacy, and security of Member information. This obligation is addressed in policies and procedures and confidentiality notices and agreements. All providers and their staff are subject to KP’s confidentiality, privacy, and security 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 PHI without written authorization, except as required or permitted by law. If the member 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 qualified 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 PHI for treatment, payment, and health care operations, and for other routine purposes, as permitted by law, such as for use in research. KP, its workforce, and business associates are required to protect the integrity, confidentiality, and availability of the ePHI (electronic PHI) to include media and device controls, physical safeguards for workstations, and limiting PHI access according to role-based employment. Providers who use, create, maintain, receive, or transmit PHI must take security measures to control access to ePHI and protect it from alteration, destruction, loss, and accidental or intentional use by or disclosure to unauthorized persons.

For more information about rights regarding PHI as well as our privacy and security practices, you may call our Member Service Contact Center at **(800) 464-4000** or **711 (TTY)** or refer to our Notice of Privacy Practices on our website at the following link:
http://members.kaiserpermanente.org/kpweb/privacystate/entrypage.do

Access and Availability

The California Department of Managed Health Care’s (DMHC) Timely Access Regulations that were implemented in early 2011 established access standards for primary care, specialty care, ancillary services, wait time for 24/7 triage/screening services and wait time for customer service.

The Centers for Medicare and Medicaid Services (CMS) recently codified appointment wait time access standards for Medicare Advantage plans members for Primary Care and Behavioral Health beginning January 1, 2024, as urgent/emergency—immediately; non-emergent/urgent but in need of medical attention—7 business days; and routine and preventive care—30 business days.

The intent of these regulations is to ensure that all health plans have adequate provider networks and staff sufficient for enrollees to access needed care and services in a timely manner. Kaiser Foundation Health Plan (KFHP) is providing oversight for these requirements by monitoring and reporting Kaiser Permanente Northern California (KPNC) performance results.

Timely access to care is an integral part of the Kaiser Permanente Northern California's health care delivery system and we're committed to offering members timely access. Providers and members can get help by contacting the Member Services Department at facilities where available or at the Member Services Contact Center at (800) 464-4000 to request assistance in getting timely access to care with an appropriate provider. Providers and members can also contact Member Services to voice a complaint about timely access or they may contact the DMHC toll-free telephone number **(1-888-466-2219**) or TTY **(1-877-688-9891)** for the deaf or hard of hearing. DMHC's website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions.

Notice of Network Provider Terminations

KP provides timely written notification within a reasonable timeframe to members who are impacted by the contract termination of a KP network provider. KFHP must notify Commercial members at least sixty (60) days prior for primary care practitioner terminations and thirty (30) days prior for specialty care practitioner termination. KFHP must notify impacted Medi-Cal members either thirty (30) calendar days prior to the effective date of a network provider contract termination or fifteen (15) calendar days after receipt or issuance of the termination notice, whichever is later. If KP is notified of a termination less than 30 days prior to its effective date, KP must immediately notify all impacted Medi-Cal members. KFHP must notify Marketplace members at least thirty (30) days prior to a primary care or specialty care practitioner terminations.

Kaiser Permanente is required to follow the federal requirements established by the Centers for Medicare & Medicaid Services (CMS) for notifying impacted Medicare Advantage plan members of provider contract terminations – specifically, beginning 1/1/2024 CMS requires that Medicare Advantage (MA) plans members be given 45 calendar days' notice (impacted enrollees) when either a primary care or behavioral health provider terminates their contract for no cause during the contract year.

- Impacted enrollees include those currently assigned to the provider and those who have been patients of the provider within the past three years.
- Written notice ***and*** one attempted telephonic notice are required, so long as the enrollee has not opted out of phone calls for plan business.

For all other mid-year specialty, no-cause contract terminations, MA plans must give at least 30 calendar days written notice to enrollees seen on a regular basis (assigned to, currently receiving care, or received care in past 3 months). Additionally, we are required to notify CMS of any significant, no-cause provider terminations at least 90 days prior to the effective date.

If the terminating primary care practitioner, primary care medical group, specialist or specialist group is providing care to KPNC Members: (a) KFHP is responsible for notifying Members prior to the effective date of termination and assuring the transition and coordination of care where clinically indicated and (b) the primary care practitioner, specialist or specialist group is responsible for providing information and otherwise assisting KFHP in making such notifications. More specific information about practitioner terminations is available at http://kp.org/continuingyourcoverage or by calling **(800) 464-4000**.

If KP enrollees or contracted providers have any questions about completion of covered services requirements, they should call KP Member Services and request a copy of the KP "Completion of Covered Services" policy.

Access to Care Decisions and Availability of Utilization Management (UM) Criteria/Guidelines

KPNC has several principles that guide the UM decision-making process. They include the following:

- Kaiser Permanente practitioners, contracted practitioners, and health care professionals make decisions about a member's care based on clinical needs in association with appropriate treatments and existence of coverage. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.
- The health plan does not reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that result in denials or create barriers to care and services. In order to maintain and improve the health of KP members, all practitioners and health professionals must be diligent in identifying any potential under-utilization of care or service.
- UM criteria and guidelines are used in conjunction with clinical judgment, and case specific consideration. The following are considered when making UM determinations, (1) member needs, such as age, co-morbidities, complications, home environment, psychosocial/cultural issues, patient safety and community resources, and (2) the capabilities of the local delivery system. When applicable, UM criteria/guidelines are used to guide UM decision-making.
- Only practitioners with current, unrestricted licenses make health care service denial decisions based on medical appropriateness or medical necessity. Board certified consultants are used to assist in making medical necessity determinations. The final decision regarding a member's treatment plan rests with the treating physician. KP makes the UM criteria/guidelines available to its practitioners, providers, and contracted practitioners and providers upon request.
- Copies of the UM criteria/guidelines are available by contacting the Member Service Contact Center at 1-800-464-4000 or 711 (TTY). For practitioner and member inquiries regarding UM issues, contact the local Resource Management (RM) Department or the Coverage Decision Support Unit (CDSU). Appropriately trained professionals are available to answer questions you might have about our referral and authorization processes, criteria, or other UM issues.

UM Criteria and Guidelines

UM Criteria/Guidelines used within KPNC are summarized in the chart below.

NCAL UM CRITERIA/GUIDELINES
Durable Medical Equipment Formulary
Ostomy and Urological Supplies
Prosthetic and Orthotic Devices
Emergency Medical Definition
Solid Organ and Bone Marrow Transplants
Medicare Rules and Regulations
Medicare Conditions of Participation
Home Health Shift Care/private Duty Nursing (PDN) Services for Commercial Members
Home Health Shift Care/Private Duty Nursing (PDN) Services for Medi-Cal members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21
Community Based Adult Services (CBAS) for Medi-Cal Members

NCAL UM CRITERIA/GUIDELINES
• Chiropractic Care for Commercial Members • Chiropractic Care for Medicare Members • Chiropractic Care for Medi-Cal Members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21 • Acupuncture for Commercial Members • Acupuncture for Medicare Members • Acupuncture for Medi-Cal Members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21 • Hyperbaric Oxygen Therapy (HBO) for Commercial Members • Hyperbaric Oxygen Therapy (HBO) for Medicare Members • Hyperbaric Oxygen Therapy (HBO) for Medi-Cal Members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21 • Behavioral Health Treatment (BHT) Services Available to Medi-Cal Members under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit • Behavioral Health Treatment Services Available to Commercial Members with Autism Spectrum Disorder (ASD) • Provision of Occupational and Physical Therapy Services for Commercial Members • Provision of Occupational and Physical Therapy Services for Medicare Members • Provision of Occupational and Physical Therapy Services for Medi-Cal Members including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21 • Provision of Speech and Language Therapy Services for Commercial Members • Provision of Speech and Language Therapy Services for Medicare Members • Provision of Speech and Language Therapy Services Medi-Cal Members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21 • Dental Anesthesia for Commercial members • Dental Anesthesia for Medicare members • Dental Anesthesia for Medi-Cal members, including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21

Denials and Practitioner Appeals

Information about a denial or the appeal procedures is available by contacting your local UM department. Please refer to the last page of this communication document for a list of local UM departments and telephone numbers. When a benefits or medical necessity denial is made, the requesting practitioner is given the following information:

- Availability of UM Physician Reviewer: The name and direct telephone number of the decision-maker accompanies a copy of the denial letter that is sent to the requesting practitioner. All medical necessity decisions are made by physicians. Physician decision-makers include, but are not limited to, DME physician champions, Assistant Physicians-in-Chief (APICs) for Outside Services (Referrals), other board certified or behavioral health practitioners. If the information is unclear, please contact the issuing department that is identified in the letter.
- If the physician or behavioral health practitioner does not agree with a medical necessity decision, the physician may contact the UM decision-maker on the cover page of the letter, or the case may be discussed with the Physician-In-Chief (PIC) at the local facility. For additional information regarding this process, please contact your local Resource Management (RM) Chief and/or local RM Department

Member Grievance Resolution

KP is committed to providing our members with quality care and ensuring prompt resolution of their grievances. Members may contact our Member Services Departments at our facilities where available or at the Member Service Contact Center at **(800) 464-4000** or **711 (TTY)** to voice their concerns or requests. Member Services representatives will advise Members about our resolution process and ensure that the appropriate parties review the member's grievance. Members may also contact the DMHC toll-free telephone number **(1-888-466-2219**) or TTY **(1-877-688-9891)** for the deaf or hard of hearing. DMHC's website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions.

We will make every attempt to resolve the member's grievance promptly and will resolve the issue as quickly as the member's health requires, but no later than the regulatory required timeframes, within thirty (30) calendar days of receipt of the written or verbal complaint, in most cases. The member or the member's physician may request an expedited review, resolved within seventy-two (72) hours, if the requested service or item had not been provided (preservice) or the requested service or item is currently being provided (concurrent) and the member or physician believes the requested service or item is medically urgent.

Members should always refer to their Evidence of Coverage (EOC) for the grievance resolution options that are applicable.

Independent Medical Review (IMR) Program

California law requires health plans to offer an IMR program to members enrolled in Commercial and Medi-Cal plans who have been denied services because the services were deemed not medically necessary or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Review Organization (IRO) Program is administered by the California Department of Managed Health Care (DMHC). If the DMHC determines that the member's case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision. For additional information you may contact the Kaiser Member Service Contact Center at **(800) 464-4000** or **711 (TTY)**.

Member Rights and Responsibilities

KPNC is responsible for informing practitioners about member rights and responsibilities. Health care practitioners are expected to be familiar with the rights and responsibilities of our members. The following is an abbreviated excerpt from the Rights and Responsibilities Section of *The Kaiser Permanente Member Resource Guide California.* Members are annually notified about how to obtain the KP Member Resource Guide California with the Member Rights and Responsibilities statement. This information is available at kp.org/resourceguide. If you would like a hard copy of the KP Member Resource Guide California, please contact our Member Service Contact Center at **(800) 464-4000** (English), **(800) 788-0616** (Spanish), **(800) 757-7585** (Chinese dialects), **or 711 (TTY**).

Members have the right to:

- Receive information about KP, our services, our practitioners and providers, and Member's rights and responsibilities;
- Participate in a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage;
- Participate with practitioners in making decisions about health care;
- Have ethical issues considered;
- Receive personal medical records;
- Receive care with respect and recognition of their dignity;
- Interpreter services, including sign language, which shall be available during all hours of operation at no cost;
- Be assured of privacy and confidentiality;

- Participate in physician selection without interference;
- Receive a second opinion from an appropriately qualified medical practitioner;
- Receive and use Member satisfaction resources, including the right to voice complaints or appeals about KP or the care we provide;
- Make recommendations regarding KP member rights and responsibilities policies.

Members are responsible for:

- Being civil and respectful, as part of Kaiser Permanente's Member/Patient/Visitor Code of Conduct;
- Knowing the extent and limitations of health care benefits;
- Notifying us if hospitalized in a non–KP Hospital;
- Identifying themselves;
- Keeping appointments;
- Supplying information (to the extent possible) that KP and our practitioners and providers need in order to provide them with care;
- Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible;
- Following the plans and instructions for care they agreed on with their practitioners;
- Recognizing the effect of their lifestyle on health;
- Fulfilling financial obligations;
- Knowing about and using the member satisfaction resources available to them, including the grievance-resolution process.

Evaluation of New Technology

KPNC maintains a rigorous process for evidenced-based health care technology assessment. For KPNC, The Permanente Medical Group (TPMG) New Medical Technology addresses technology inquiries from TPMG physicians and KFHP representatives. TPMG New Medical Technology considers pertinent clinical evidence and TPMG clinical expert opinion on the safety and effectiveness of novel devices, procedures, tests, and treatments for specific clinical indications. TPMG New Medical Technology also participates in the Interregional New Technologies Committee (INTC) for timely and objective evaluations of new medical technologies and new applications of existing medical technologies to help medical and behavioral health practitioners across KP, all represented on the INTC, make informed clinical care decisions. Within KPNC, TPMG clinical chiefs and leadership decide which new medical technologies to integrate into TPMG clinical practice. As necessary, the KP California Benefit, Contract and Policy Committee reviews medical technology deployment decisions to identify any impacts on Health Plan benefits.

Northern California Quality Program and Patient Safety Program

The KPNC Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation, licensing, and other elements. The quality improvement program assures that quality improvement is an ongoing priority of the organization. Quality activities can include, but are not limited to, quality improvement and peer review, identification of clinical and administrative system issues that impact care delivery, credentialing and privileging, submission of reports to state and federal regulatory bodies, and public reporting of data as governed by law and regulation.

Information about our quality program is available to you in the *Quality Program Description at KP* document, including:

- Awards and recognition for our quality program presented by outside organizations
- Programs and systems within KP that promote quality improvement and health equity
- Our quality improvement structure
- Areas targeted by our quality goals

- To obtain a copy of this document, call our Member Service Contact Center at (800) 464-4000 or 711 (TTY). Ask for a copy of Quality Program at KP. Alternatively, you can view and print the document by visiting the KP website at http://www.kaiserpermanente.org and clicking on "Patient Quality & Safety".

At KP, patient safety is every member's right and everyone's responsibility. We achieve this vision through precise and efficient execution of evidence-based strategies in Infection Prevention, Clinical Safety, Risk Management and Optimization of the Safety Culture that demonstrate broad inclusion of the patient experience. If you would like independent information about KP's health care quality and safety, the following external organizations offer information online:

- The not-for-profit National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. You can review the report card for Kaiser Foundation Health Plan, Inc., Northern California, at http://www.ncqa.org.

- The Leapfrog Group is a national nonprofit organization that encourages purchasers and consumers to review their hospital performance reports to make informed decisions. The group gathers information about medical care and patient safety via an annual Leapfrog Survey and biannually via the Safety Grades. All Kaiser Foundation Hospitals in California participate in the survey. To review survey results, visit: http://www.leapfroggroup.org/cp. To review the Safety Grades, visit: https://www.hospitalsafetygrade.org/.

- The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit: https://reportcard.opa.ca.gov/.

Population Health Management (PHM), Disease Management and Complex Case Management Program

PHM is a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychological well-being of individuals and address health disparities through cost-effective and tailored health solutions.

KP has disease management programs available to help empower individuals with chronic conditions to better understand and manage their disease. Disease management consists of population/care management programs for members with asthma, diabetes, coronary artery disease, congestive heart failure, and chronic pain. In addition, KP has a care management program for members with special needs, which may include members with multiple and/or complex chronic conditions.

The population health management programs involve assessing and stratifying the population of Members with specific conditions into smaller subgroups. The subgroups are divided according to their care needs and objectives: "low risk" members who have well controlled conditions and "higher risk" members who require additional interventions. Based on the members' clinical condition, the members may be followed in care management to help address their individual care needs.

Complex case management uses an interdisciplinary care team approach, which includes nurses and social workers to support members with multiple chronic conditions and/or high utilization who would benefit from active case management to improve their self-management skills. Case managers work actively with the member and their caregivers to achieve defined goals.

Practitioners who have identified KP members who would benefit from these programs are highly encouraged to refer them by contacting the relevant care management department at the closest KP facility.

Clinical Practice Guidelines (CPG)

KP supports the development and use of evidence-based CPGs and Practice Resources to aid clinicians and Members in the selection of the best prevention, screening, diagnostic, and treatment options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. Available CPGs include those for key preventive and non-preventive acute and chronic medical conditions. They provide recommendations for the preferred course of action, while recognizing the role of clinical judgment and informed decision making in determining exceptions. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are distributed to practitioners and copies of the guidelines can be obtained by calling (510) 625-6343 or on the clinical library: http://clm.kp.org.

Patient Centered Medical Home (PCMH) Recognition

NCQA Patient Centered Medical Home (PCMH) Recognition is awarded to primary care practices that meet specific standards and provide high-quality care while managing the overall health of their patients. During this annual review process, NCQA validates that the primary care practices are reliably demonstrating care activities consistent with the PCMH model and compliance with the most current PCMH Standards & Guidelines.

Key elements with the PCMH model include:

- Team Based Care and Practice Organization
- Knowing and Managing your Patients
- Patient Centered Access and Continuity
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

Currently all 62 sites of Northern California primary care practices are PCMH Recognized, and their recognition is renewed annually.

This Northern California NCQA Update letter applies to you as a Provider for products offered by Kaiser Permanente Medical Care Program Affiliated Payors, as referenced in your Agreement with a Kaiser Permanente entity.

To the extent provided in your Agreement, if there is a conflict between this letter and your Agreement, the terms of the Agreement will control. The term "member" as used in this letter refers to currently eligible enrollees of plans offered by Kaiser Permanente Medical Care Program Affiliated Payors, including Kaiser Foundation Health Plan, and their beneficiaries. The term “provider” as used in this letter refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement. Additionally, “you” or “your” in the letter refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement and “we” or “our” in the letter refers to Kaiser Permanente. Capitalized terms used in this letter may be defined within the letter or if not defined herein, will have the meanings given to them in your Agreement.