KAISER PERMANENTE®

Dear Contract Practitioner:

The Southern California Permanente Medical Group (SCPMG) and Kaiser Foundation Health Plan, Inc. annually communicates to all employees, practitioners, and providers to reaffirm our policies, processes, and practices in these and other areas:

- Member-Practitioner Communication and Protection of Confidentiality
- Utilization Management
- Member Rights and Responsibilities
- Quality Improvement Program and Quality-Related Efforts
- Equity, Inclusion & Diversity Program and Language Assistance
- Nondiscrimination in the delivery of health care services and acceptance of any member in need of health care services for treatment

Additionally, this letter will inform you of our quality goals, access standards, and the availability of information about the Quality Improvement program:

Member-Practitioner Communication

A basic value of Kaiser Permanente (KP) is that patients are treated with sensitivity, dignity, and respect. We are committed to providing culturally competent medical care and culturally appropriate services to improve the health and satisfaction of our increasingly diverse membership. Kaiser Permanente collects member demographic information such as race, ethnicity, language preference and religion, to further assist our efforts to reduce health disparities and provide quality culturally competent care. We believe that quality 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 policies set forth by Kaiser Permanente. Kaiser Permanente allows open practitioner-patient communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing medically necessary or appropriate care. Kaiser Permanente does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for utilization management (UM) decision makers do not encourage decisions that result in underutilization.

If a member expresses to the practitioner that they are dissatisfied with the treatment plan and/or the practitioner's decision on the member's request for a service/item, the practitioner should discuss the member's dissatisfaction with them. As the treating physician, if you do not believe that a request from a patient for a service including consultations, tests, or medications is medically indicated, you do not have an obligation to provide these to the patient.

Confidentiality and Protection of Privacy Policy Statement

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

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

Members/patients have a qualified right to access their own protected health information, as provided by law. Members/patients also have the right to authorize, in accordance with applicable law, the release of their own protected health information to others.

Kaiser Permanente may collect, use, and share protected health 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.

If KP enrollees or contracted providers have any questions about continuity of care laws they should call KP Member Services and request a copy of the KP continuity of care policy.

Member Rights and Responsibilities

The following is an abbreviated excerpt from the Rights and Responsibilities Section of the Kaiser Permanente Member Resource Guide for California. This guidebook is mailed to all Medicare and Medi-Cal Health Plan members after they enroll with Kaiser Permanente, and annually thereafter. For all other members, it is available for download on kp.org or by calling the Member Services Contact Center at 800-464-4000.

Members have a right to:

- Receive information about Kaiser Permanente, our services, our practitioners and providers, and their 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 and providers in making decisions about their health care
- Have ethical issues considered
- Receive personal medical records
- Receive care with respect and recognition of their dignity
- Use interpreter services at no cost
- Be assured of privacy and confidentiality
- Participate in doctor 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 make appeals about Kaiser Permanente or the care we provide
- Make recommendations regarding Kaiser Permanente's member rights and responsibilities policies

In addition, the State of California affords Medi-Cal members specific rights, including the right to:

- Be provided with information about the health plan and its services, including covered services, Network Providers, and member rights and responsibilities
- Have timely access to Network Providers
- Know the names of the people who provide their care and what kind of training they have
- Get care in a place that is safe, secure, clean, and accessible
- Voice grievances, either verbally or in writing, about the organization or the care received
- Receive care coordination
- Request an appeal of decisions to deny, defer, or limit services or benefits
- Receive free legal help at their local legal aid office or other groups
- Formulate advance directives
- Request a State Fair hearing if a service or benefit is denied or if they did not get a decision within 30 days of a filed appeal, including information on the circumstances under which an expedited fair hearing is possible
- Disenroll and change to another managed care plan in the county where they live

- Access Minor Consent services
- Receive written Member informing materials in alternative formats, including Braille, large size print, audio, and accessible electronic formats, upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12)
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Discuss truthfully information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage
- Receive copies 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
- Have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the KP network pursuant to federal law

Members are responsible for:

- Being civil and respectful
- Knowing the extent and limitations of their health care benefits
- Notifying the Health Plan if they are hospitalized in a non-KP Hospital
- Identifying themselves, including using ID cards properly
- Keeping appointments
- Supplying information (to the extent possible) that Kaiser Permanente and its practitioners and providers need in order to provide their care
- Understanding their health problems and participating in developing mutually agreed-upon treatment goals to the highest degree possible
- Following the plans and instructions for care they have agreed on with their practitioners
- Recognizing the effect of their lifestyle on their health
- Fulfilling financial obligations
- Knowing about and using the member satisfaction resources available, including the dispute resolution process

Regional Equity, Inclusion & Diversity

Kaiser Permanente Southern California (KPSC) continues to recognize the importance of equity, inclusion, diversity and cultural responsiveness in the quality and effectiveness of healthcare delivery. We must recognize the need to be responsive to our diverse workforce, the communities that we serve and demonstrate compliance with regulatory bodies.
Kaiser Permanente requires all contracted practitioners to comply with the Kaiser Permanente Language Assistance Program (LAP) regulations for all KP members who are Limited English Proficient (LEP), including members who require sign language services. Contracted Practitioners and their staff must ensure that KP Members, their family, caregivers and legal guardian(s) receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and in their preferred language.

Language assistance must be offered to KP Members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. The proactive offer, use and/or refusal of language assistance services must be documented in the member's medical record, even if the communication occurred directly with a concordant Practitioner. High quality and timely language assistance that is free of charge and available during all hours of business must be provided to all KP members. If facility or place of business is open 24 hours/day, 7 days/week, then language assistance is to be made available 24 hours/day, 7 days/week. Kaiser Permanente also requires contracted providers and their staff to comply with ADA regulations in providing Auxiliary Aids and Services, free of charge, for members and their companions who are Deaf or hard of hearing in order to ensure effective communication. Please refer to the: Qualified Interpreter Services for Limited English Proficient Persons Policy CA.HP.Operations.LA005002- https://healthy.kaiserpermanente.org/southern-california/get-care/interpreter-services

Contracted Practitioners must have a process in place to ensure the clinical and office staff have ongoing competency of Kaiser Permanente LAP regulations to include: how to access KP language vendors for interpreter services; how to report any problems regarding KP language vendors; the need to offer, and how to document the use and refusal of interpreter services; the need to utilize only qualified bilingual staff or language vendors to provide interpreter services to KP members; and how to respond if a member requests a translated document or alternate format for written materials and knowledge on providing Auxiliary Aids and Services for Deaf or hard of hearing in order to ensure effective communication.

Contracted Practitioners must document and report information necessary for KP to assess compliance and cooperate with KP by providing documentation and reporting upon request.

For questions or additional information, contact the Southern California Regional Equity, Inclusion & Diversity Program at 626-405-6252.

Access to Care Decisions, Resource Management and Availability of Utilization Management Criteria/Guidelines

Kaiser Foundation Health Plan (KFHP) ensures the appropriate use of Medical and Behavioral healthcare services across the continuum of care through the implementation of a Utilization Management (UM) Program for all KFHP members to include a Drug Utilization Management Program and Prescription Drug Plans for KFHP Medicare Advantage members. The Utilization Management Program ensures that members receive full disclosure, timely notice and explanation of UM decisions and appropriate access to services. Requests for health care services, submitted to the Health Plan by a treating provider, are reviewed to determine whether the requested service is medically necessary[1] and within the terms of the health care coverage. The requested service may be approved, modified, delayed or denied by the Health Plan; based upon utilization management criteria which are developed in consultation with actively practicing

[1] For Medi-Cal, the term "Medically Necessary" will include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include EPSDT requirements.

physicians and consistent with sound clinical principles and processes. UM criteria are reviewed, revised as needed and approved at least annually by KFHP. Decisions may be rendered prospectively (prior authorization), or concurrently (as services are delivered).

UM decision making processes, include:

1) **Prior Authorization – Review and Decision**: When prior authorization (PA) is required, any practitioner request for a PA listed service must be reviewed and approved by the Plan prior to care being rendered. The prior authorization review and decision is made by the KFHP UM departments with appropriate physician support for decisions that deny, modify or delay a requested service. Prior authorization is performed by utilizing UM criteria which is developed in accordance with statutory requirements and accreditation standards and consistent with professional standards of care. Prior authorization reviews are processed according to the urgency of the request. Southern California Permanente Medical Group (SCPMG) and most contracted providers are not required to obtain prior authorization from KFHP for most health care services. However, there is a list of services that do require prior authorization (pages 7-9).

    - **Out of Plan Referrals**: Prior authorization is required for all out of plan referrals requesting consultation and/or treatment. Physician requested Outside Care Referrals are processed through the Outside Referrals Department (ORD).

    - **Out of Plan – Second Opinions**: Members have a right to a second opinion. An out of plan referral for second opinion is reviewed to determine whether Kaiser Permanente has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed in Plan to obtain a second opinion. When an appropriate qualified physician is not available in Plan, the referral is authorized.

    - **Out of Plan – Organ Transplantation**: Physicians may refer members for Organ Transplantation Evaluation for heart, lung, heart/lung, liver, small bowel, simultaneous kidney pancreas, pancreas alone and blood/marrow (stem cell) transplantation. Members are referred to contracted Centers of Excellence (COE) within the Kaiser Permanente National Transplant Network (NTN). Referrals outside of the NTN are facilitated through an exemption process. The referring specialist may discuss the member's case in an organ specific case conference. The referring specialist and/or other specialists participating in the case conference review the case and determine whether the member is a potential candidate for organ transplant. In adult Nephrology, dedicated nephrologists review end stage renal disease (ESRD) cases for appropriateness of referral to a transplant COE for final determination of kidney transplant candidacy. If a Member is deemed to be a potential candidate for transplant, the referring physician and member are notified and a referral to the appropriate transplant COE is arranged. Cases approved by the organ-specific transplant case conference are referred to the appropriate transplant COE for final determination of transplant candidacy. If a COE determines that a member is not a suitable candidate for organ or stem cell transplantation, the member may request a second opinion. The National Transplant Services (NTS) organ-specific case conference reviews the organ-specific patient referral guidelines at least twice annually.

2) **Concurrent Care Authorization – Review and Decision**: Any out of plan practitioner request to extend a previously approved ongoing course of treatment, requesting additional time or adding to the number of treatments, is subject to prior authorization. Unless the request meets the definition of urgent care, the request for an extension of services may be handled as a new request and decided within the time frame appropriate for the type of decision.

3) **Standing Referrals**: Within KP's integrated care delivery system, the health plan does not require primary care physicians to obtain an authorization to refer a member to a PMG specialist. Furthermore, specialists within the PMGs are not required to seek authorization from the health plan regarding how often or how many times the specialists may see the member. Rather, the PMG specialists determine how to treat the member based on their professional judgment and consultation with the member. In those situations where a member is referred to a non-PMG provider, the referral is made pursuant to a medical necessity determination as approved by KP in consultation with the referring Kaiser physician, the external specialists, and the member.

   If you believe that the medical care, test or procedure that you desire for your patient is not available within Plan, the following steps are required:
   - Request for out-of-plan specialty services is sent to the Outside Referral Department (ORD). The request is reviewed, approved or denied by the designated Chief of Service (COS) or Assistant Area Medical Director (AAMD). Requesting Contract Physician would discuss need for out-of-plan care with an appropriate SCPMG Physician and/or ORD.
   - If the patient is insisting on seeking out-of-plan care, and after consultation with the Chief of Service, it is deemed that medically appropriate care is available within Plan, the patient should be advised that he/she may submit a claim and/or a grievance through Member Services.
   - If you have any questions, you may contact your Chief of Service or AAMD.
   - Kaiser Permanente provides a toll-free number, (800) 464-4000, for all practitioner and member inquiries regarding UM issues. You may also contact the Regional Utilization Compliance (RUC) at (626) 405-3130. Trained professionals are available to answer questions you might have about KPSC referral and authorization processes, criteria or other UM issues. Outside of normal business hours, a self-servicing interactive voice response system prompts the member/practitioner, so that inquiries related to general UM processes or specific UM issues can be left on a voice messaging service. All voice messages left outside of normal business hours, are responded to no later than the next business day.

Practitioner requested services that require Health Plan prior authorization and/or concurrent authorization include:

PRIOR AUTHORIZATION LIST AND UTILIZATION MANAGEMENT CRITERIA

UTILIZATION MANAGEMENT GUIDELINES AND CRITERIA	
SERVICE Requiring Prior Authorization	**GUIDELINES**
Acupuncture Services	Contact your local Pain Management, Physical Medicine and Rehabilitation,

UTILIZATION MANAGEMENT GUIDELINES AND CRITERIA	
SERVICE Requiring Prior Authorization	**GUIDELINES**
	Neurology/Headache program, Oncology, Rheumatology or OB/GYN Departments, Outside Referral Department (ORD), Regional Utilization Compliance and Consultation (RUC)
Behavioral Health Treatment/Applied Behavioral Analysis (for re-authorization requests only) Initial referrals for ABA are not subject to prior authorization. At such time continued treatment is evaluated for medical necessity review and authorization is required	For re-authorization only. Available by contacting RUC
CBAS – Community Based Adult Services (for Medi-Cal recipients)	Available by contacting Complex Case Management Department.
Dental Anesthesia	Available by contacting the local Outside Referral department servicing the areas, or RUC
Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)/Soft Goods	Formulary based. Available by contacting the local DME Department, RUC, or online in the Clinical Library
External (Out-of-Plan) Referrals	Please consult with your local Chief of Service or Medical Director; contingent on whether medical care is available with SCPMG/KFH. For Contract Physicians contact ORD.
Home Health Continuous Shift Care and Home Health Shift Care/Private Duty Nursing for Medi-Cal Children (EPSDT)	Contact your local or regional Home Health Departments, o r RUC
Home Venipuncture	Available by contacting RUC
Occupational, Speech, and Physical Therapies (for re-authorization requests only for Autism or Developmental Delay)	Used only when services are requested by non-SCPMG practitioners. Contact your local Physical Medicine and Rehabilitation Department, local Outside Referral Departments servicing the areas, and RUC
Transplants – Solid Organ and Bone Marrow	Available by contacting the RUC, Transplant HUB or the Center of Excellence involved with patient's care
Plastic Surgery Consultation for Breast Reduction Mammoplasty	Contact the RUC or your local Plastic Surgery Department
Plastic Surgery Consultation for Panniculectomy	Contact the RUC or your local Plastic Surgery Department

UTILIZATION MANAGEMENT GUIDELINES AND CRITERIA	
SERVICE Requiring Prior Authorization	**GUIDELINES**
Spinal Cord Stimulators for the Management of Chronic Pain	Available by contacting local Outside Referral Departments servicing the areas or RUC

There are no financial rewards or incentives that exist which could encourage decisions that would specifically result in underutilization, denials of service, or create barriers to care and service. All practitioners and health professionals should be especially diligent in identifying potential underutilization of care or service, to maintain and improve the health of our members.

Denials of Practitioner Requested Services and Appeals

If a physician requests a health care service on the member's behalf and that request has been reviewed, approved, modified or delayed as a result of Utilization Management (UM) review, the member and provider receive written notice of the decision. The written communication includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision;
- A description of the utilization review criteria used, and the clinical reasons for the decision regarding medical necessity;
- Information describing how the member may file a grievance with the Plan and, in the case of Medi-Cal members, information and explanation how to request an administrative hearing in compliance with Title 22 of the California Code of Regulations;
- Notice of availability of language assistance services;
- Written notice to physicians or other health care providers of a denial, delay, or modification of a request, including the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension that allows the physician or health care provider easy access to the professional responsible for the UM decision. UM staff and physicians are available during normal business hours to assist members and physicians with UM concerns;
- Written Notice to the physician and member with information on Independent Medical Review.

Denial notices are issued in accordance with applicable regulations and accreditation standards. In partnership with the Regional Utilization Compliance (RUC), the Health Plan Physician Advisor (HPPA), Health Plan Regulatory Services Department (HPRS) and the Medicare Compliance Department, Kaiser Foundation Health Plan (KFHP) provides direction and oversight of the process of issuing written notification of non-coverage to KFHP members.

When a member receives notice that a provider requested service has been denied or modified through the plan's utilization review process, the member has a right to appeal and is given information on the process to appeal the UM decision through Member Services.

- **Member Complaints and Appeals**: Members may contact Member Services Departments at any of our local facilities or at the Member Services Contact Center at (800) 464-4000 to voice complaints or requests for a proposed treatment plan not resolved in the practitioner's office. Member Services representatives will advise members about our resolution process and ensure that the appropriate parties review

the member's complaint or request. Kaiser Permanente makes every attempt to resolve the member's issue promptly and no later than the required time frame. The member or the member's physician may request an expedited review (resolution timeframe within 24 to 72 hours, depending on type of request) if the requested service or item has not been provided (pre-service) 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.

- **External/Independent Medical Review Program Availability**: Health plans are required to offer an external/independent medical review program to members at no cost. Requests for health care services that have been denied by the Plan because the services were deemed not medically necessary or considered experimental or investigational (a "health care dispute") are eligible for IMR. This includes a Plan denial of claim payment for emergency and urgent care services from non-Kaiser Permanente providers. The California Department of Managed Health Care (DMHC) and Center for Medicare and Medicaid Services (CMS) contracts with an Independent Review Organization (IRO) that reviews member requests for external/ independent medical review. If the DMHC or CMS determines that the member's case qualifies for an independent medical review, medical experts not affiliated with Kaiser Permanente will conduct the review. Kaiser Permanente will honor the DMHC or CMS decision. For information, you may contact the Member Services Contact Center at (800) 464-4000.

Regional Complete Care Support Programs

Kaiser Permanente Southern California Region's Complete Care Support Programs uses an evidence-based, population approach to provide care for members across the spectrum of health: healthy; well but with specific health issues; chronically ill; and end of life. Disease management is imbedded in our care delivery system, touching the patient before, during, after, and between visits. We use every encounter to provide the member the care they need, including preventive care, care based on risk factors, and/or care based on chronic diseases. Our approach is patient-centric – not disease-centric – focusing on the members' individual health profile.

Kaiser Permanente believes that preventive care and a healthy lifestyle make a big difference in everyone's life. That is why disease management has always been built into the care delivery model, and our programs for those with chronic conditions deliver care for members' total health at every stage of life.

Rather than have separate, incremental programs for select populations, Kaiser Permanente has a comprehensive approach toward conditions such as asthma, cancer, cardiovascular disease, chronic pain, diabetes, depression, and weight management. As we are an integrated care delivery system, it is convenient for members to manage multiple conditions because all necessary services are likely to be in the same location. It is what makes our Complete Care approach different and what makes it work so well.

Kaiser Permanente has implemented the following functional strategies to address the member's needs at every encounter:

Proactive Encounter includes processes, tools, and workflows which support the health care team prior to, during, and after patient interactions. This work impacts all care settings, helping to address and document any gaps in a patient's care, including needed preventative care.

Proactive Panel Management entails clinicians and staff assisting with follow up on primary care physician (PCP) patient panels, particularly intervening on those members not actively seeking care from their PCP. The health care team identifies members with gaps in care and brings recommendations to the physician who then directs the team to carry out the approved orders.

Centralized Outreach uses batch mechanisms to engage members in positive health behaviors for preventive and chronic care. This function helps to improve existing outreach efforts, efficiently launch new evidence-based initiatives, and expand outreach capacity through coordination, consolidation, and new technologies.

Case/Care Management involves licensed Case/Care Managers working within their scope of practice or under protocol. Patients with care gaps across a wide range of programs or initiatives are targeted for intervention. Patients may be involved in programs over short term or ongoing time periods. They may receive in-person or remote interventions or both.

The Heart Failure Transitional Care Program is evidence-based with the goal of improving clinical quality (The Joint Commission Heart Failure bundle), reducing hospital days/readmission rate, and improving patient quality of life. This combines inpatient care management, home health evaluation, and outpatient care management to provide early intervention and reduce the risk of readmission.

Medication Adherence incorporates physicians, pharmacists, registered nurses, and other advanced practice caregivers providing medication therapy, education, and drug information to patients. They utilize evidence-based guidelines, standardized practices, and tools to optimize pharmacologic efficacy and improve clinical outcomes. Clinicians are trained to identify barriers and offer solutions to help patients use medications correctly. In addition, patients overdue for refills for certain medications, or those who have low adherence to taking certain medications, receive telephone outreach via recorded message or from a pharmacist.

SureNet is a centralized outpatient team of LVN's and RN's that work on limited scope projects. Projects focus on patient safety through medication monitoring, potentially harmful interactions, diagnosis detection, and necessary follow-up care.

On-line Personal Action Plan provides person-focused information about care gaps, prevention, and lifestyle management via our kp.org portal. Patients can assess their risk for cardiovascular disease, learn about wellness coaching and education, and take steps to be activated in improving their health.

Transgender Care Management Program consists of a team of nurses who support transgender members in accessing Transgender Surgery. The nurses support patients in meeting WPATH and endocrinology society guidelines for surgery. They also partner with mental health, endocrinology, primary care, gynecology, and other specialties to ensure patients are medically optimized for surgery.

Care Coordination and Case Management

Kaiser Permanente offers case management programs for the coordination of health care and for continuity of care across the continuum. These programs promote high-quality, cost-effective care and services for members through the proactive provision of care coordination, targeted education and resource management.

Members who meet pre-established criteria may be automatically enrolled into the case management programs. Referrals to the case management programs may be made by any member of the healthcare team to include, physician, nurse, case/care manager, social worker, by the member's caregiver or by the member him/herself. The case/care management programs offered include:

Complex Case Management programs through Complete Care have been established for patients with poorly controlled and/or complex conditions. The goal is to optimize member wellness, improve clinical outcomes and promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resources, and advocacy. The following specialty Case Management programs are offered:

- **End Stage Renal Disease Care Management Program** which manages the complex needs of the member with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). The program seeks to maximize health potential while assuring appropriate utilization of resources. For more information, or to make a referral, please call 1-323-783-7393.

- **Southern California Transplant HUB** which provides case management and care coordination to members who are being considered for solid organ or stem cell transplantation. The program focuses on coordination of care between Kaiser Permanente and contracted Centers of Excellence (COE) as the member progresses through the transplant care continuum. For more information, please call 323-783-5151.

- **Patient Centered Medical Home (PCMH) model** which focuses on providing personalized, comprehensive and evidence-based medical care using a physician-led team of professionals. PCMH promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions based on the fullest understanding of information in the context of a patient's values and preferences. To make a referral, please contact the member's Primary Care Physician (PCP).

Regional Care Coordination / Case Management Program (RCCCM) is available to all KP Medi-Cal members. RCCCM Program targets members who are most vulnerable and high-risk with complex health care needs with high utilization due to uncontrolled chronic conditions, limited functional status, or with underlying social determinants of health. RCCCM provides intensive, personalized case management and services coordination for enrolled members. A member-centric care plan is developed, shared with the PCP and multidisciplinary care team members. Members are discharged from the program once goals are met or when members no longer wish to participate. Members are identified through referrals and risk-stratification reports. Members have the option to participate in or decline the RCCCM Program. For more

information please call: 1-866-551-9619, or to make a referral email RegCareCoordCaseMgmt@kp.org.

Care coordination and case management services by RCCCM are available to all KP adult and pediatric members including all lines of business such Medi-Cal Seniors and Persons with Disabilities (SPDs), Medicare Advantage Plan Members, Medicare Advantage and Medi-Cal Plan (SNP) Members. The RCCCM case managers outreach to high-risk members to conduct a health risk assessment (HRA) within specified timeframes per regulatory requirements. Based on the HRA results, RCCCM case managers will use members' input to develop member-centric care plans, coordinate health care services and community-based services, and share the care plan with the PCP as appropriate.

Enhanced Care Management (ECM) services are the most intensive form of care management and are available to the most vulnerable members of certain Medi-Cal populations of focus, including individuals and families experiencing homelessness, adult high utilizers, adults with severe mental illness (SMI) or substance use disorder (SUD), individuals transitioning from incarceration, individuals at risk for institutionalization and eligible for long term care services, nursing facility residents who want to transition to the community. ECM services will also be available as of July 2023 for children and youth (up to age 21) who are experiencing homelessness, are high utilizers, have serious emotional disturbance (SED) and are identified to be at clinical high risk for psychosis or are experiencing a first episode of psychosis, are enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs, are involved with or have a history of involvement in child welfare, including foster youth up to age 26, and are transitioning from incarceration. These services offer an in-person component and include outreach, assessment and care management plan, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports, and coordination of and referral to Community and Social Support Services. Members are offered ECM services based on their inclusion in the populations of focus, listed above, or by referral.

Special Needs Plan (SNP)

Kaiser Permanente (KP) offers a Special Needs Plan (D-SNP) called Senior Advantage Medicare and Medi-Cal Plan, for its dual eligible members. Dually eligible persons tend to have complex, high cost, high medical and psychosocial needs. Members must have both Medicare and Medi-Cal benefits with Medicare assigned to Kaiser Permanente.

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:

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 barriers and other significant barriers
- Major diseases, co-morbidities, chronic conditions
- Social, cognitive, and functional limitations

1) **Care Coordination**: The SNP MOC details key roles and responsibilities of the care coordination process including a comprehensive assessment, referral and facilitation of 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 a 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 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, caregiver support (if applicable), LTSS service and other needs.
    - **Development of an Individual Care Plans (ICP)**: Based on the HRA results, SNP care managers develop a care plan that includes goals, interventions, and self-management. The care plans are updated and routed to the member's primary care physician (PCP) for review and follow up as appropriate.
    - **Collaboration of an Interdisciplinary Care Team (ICT)**: The ICT comprises of multiple disciplines and may include the PCP, case manager, dementia care specialist, social services, 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. SNPs are to provide a face-to-face, including telehealth, encounter with each SNP member at least annually with a member of the ICT.
    - **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, a review of medications and future appointments are discussed, barriers are identified, referrals to appropriate community-based services are made, and the SNP ICP is updated.

2) **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 networks additional responsibilities that include, but are not limited to:
    - The use and knowledge of KP approved clinical practice guidelines (CPG) when providing care to the SNP population; under certain circumstances and/or when CPG are unavailable, KP providers shall make decisions based on clinical expertise.
    - Ensuring continuity of care when a care transition occurs.
    - To review additional detail of the MOC training material, please see Attachment I.

3) **MOC Quality Measurement & Performance Improvement**: The SNP MOC must illustrate KP's overall quality measurement and improvement plan, which includes the following:
    - Identification of key stakeholders (i.e., SNP leadership, SNP management groups, 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 Care of Older Adult measures – Medication Review, Functional Status and Pain Screening, 30-Day Readmissions and process measures).
    - Description of the methodology to measure member satisfaction with the SNP program.

For more information or assistance, please call your local SNP program.

Kaiser Permanente Southern California Region			
Medical Center SNP Programs Main Telephone Numbers			
Medical Center	SNP Main Tel #	Medical Center	SNP Main Tel #
Antelope Valley	866-324-0010	Riverside	951-358-2664
Baldwin Park	877-347-5176 626-851-7046	San Bernardino County	909-609-3508 909-609-3736
Downey	562-622-3820	San Diego	866-300-0019
Kern	661-398-3855	South Bay	424-251-7516
Los Angeles	323-783-3230	West Los Angeles	323-900-7500
Orange County	714-734-4590	Woodland Hills	818-592-2427
Panorama City	866-331-8042 818-375-2940		

Pharmaceutical Management

Kaiser Permanente is committed to providing our members with high quality, cost effective medical care. The Drug Formulary was created and is regularly updated by the physician leaders of the Regional Pharmacy and Therapeutics (P&T) Committee in collaboration with the Chiefs of Service of all specialties. Kaiser Permanente bases all formulary decisions on reliable clinical evidence. Cost is considered when equivalent effective and safe medications have different costs. Kaiser Permanente encourages the use of quality generic products when available. Kaiser Permanente maintains an internal pharmacy quality department to assure that our members receive appropriate high quality generic products.

In order for members to take advantage of their Drug Benefit, the Contract Practitioner must prescribe drugs and medications in accord with Kaiser Permanente's Formulary program. The Kaiser Permanente Online Drug Formulary is your one source for formulary and drug information. The content is continually updated, providing access to currently available information, including FDA Boxed Warnings, special alerts, and medication safety issues. The Kaiser Permanente Online Drug Formulary can be accessed at: http://online.lexi.com/lco/action/home/switch?=kaico_f

If the prescription is filled, members will be charged the member costs for these medications specific to their Health Plan Benefit. Prescriptions for medications that are not on the Kaiser Permanente Drug Formulary ("non- formulary medications") are not covered by the Kaiser Foundation Health Plan (KFHP) Drug Benefit. If the Contract Practitioner assesses that a non-formulary medication is medically necessary, i.e., patient is allergic, intolerant to or has tried other formulary alternatives within that class or a different class of medications, the Contract Practitioner should indicate the specific medically necessary exception on the prescription order. "Patient request" for a non-formulary medication, including "patient request" for a non-formulary brand medication, when a quality generic is available, does not meet the definition of "medical necessity". In some cases, the Contract Practitioner will be contacted by a Kaiser Permanente pharmacist, or a pharmacist under contract with Kaiser Foundation Health Plan, Inc., to discuss and consider prescribing available alternative formulary medications when a non-formulary medication has been prescribed.

A Kaiser Permanente pharmacist, or a pharmacist under contract with Kaiser Foundation Health Plan, Inc., may dispense a generic equivalent to a brand drug prescribed by Contract Practitioner consistent with California law, unless for each prescription for each individual patient, the Contract Practitioner has specified "dispense as written" or DAW.

Kaiser Permanente may request that the Contract Practitioner participate in the Kaiser Permanente substitution and conversion programs, as approved by the Kaiser Permanente Regional P&T Committee. Kaiser Permanente does not use step-therapy protocols in the administration of its prescription drug benefits.

Within the formulary process, there are certain medications which are "Restricted" to designated physician specialists. This restriction process helps to assure the proper use of drugs with significant potential for inappropriate usage and drugs with significant potential for toxicity or monitoring. If the Contract Practitioner prescribes a drug that is "Restricted" to a specialty other than that of the Contract Practitioner, they may be contacted by a Kaiser Permanente pharmacist, or a pharmacist under contract with Kaiser Foundation Health Plan, Inc., to verify a consultation with a prescriber of the restricted specialty. Some medications (e.g., those with high cost, high risk or high diversion potential) are further limited to a 30-day supply every 30 days and are listed on the 30/30 Drug List.

A cosmetic prescription is any prescription that is used primarily to improve appearance, even when the appearance problem is related to some other medical problem (such as unwanted hair caused by a hormonal imbalance or hair loss caused by cancer chemotherapy). Cosmetic treatments of common skin conditions are NOT a covered Health Plan benefit. As such, if a prescription is filled, all patients will be charged the full member cost for these medications. Any physician can prescribe cosmetic products as a courtesy to our members, when appropriate. All patients will be charged Member Rate specified within his/her Health Plan Benefit.

Updated information will be communicated to Contract Practitioners through e-mail, regular mail, telephone or other means. It is important that the Contract Practitioner follow the most current pharmaceutical management policies and procedures. In order for KP to communicate up-to-date information, Contract Practitioners may be asked to supply Kaiser Permanente with their individual e-mail addresses and notify Kaiser Permanente whenever there is a change to that e-mail address.

Kaiser Permanente continually evaluate prescription patterns for a variety of drug classes to assure that members consistently receive the highest quality health. In all cases, individual physicians are expected to exercise their best judgment in deciding on the most appropriate medications to prescribe for their patients.

Clinical Quality Goals

As we look at the KPSC goals for 2022, our members continue to need our support with their health care needs, whether those needs are related to acute/chronic care or preventive care. KPSC also recognizes that as an organization, we need to continue to address inequities in healthcare and recommit to our efforts to shrink disparities in health outcomes. The challenges presented to us in the past twelve months have been substantial, and the performance targets are in part aligned to achieve levels that we achieved in prior years.

Maintaining high performance in most of the clinical measures continues to be an imperative. KPSC clinical quality results are published in several venues for publicly reported clinical quality metrics (e.g., NCQA Commercial Ratings, Medicare 5-Star, CMS, CA Office of the Patient Advocate, Covered CA, and the Integrated Healthcare Association AMP (Align Measure Perform)). Each of these organizations may use different cut points for categorizing, or rating, our clinical quality, which makes it challenging to manage and monitor performance for these publicly reported measures.

The methodology for calculating the Ambulatory Quality Composite (AQC) Score allows us to consider a spectrum of measures that are publicly reported by NCQA, CMS, and the Office of the Patient Advocate (now known as the Center for Data Insights and Innovation), including measures that are being monitored and measures with targeted improvement efforts. Individual measure targets for the AQC may be set to the highest benchmark across different rating systems to maintain our strong clinical quality performance; targets may also be set at a level that will move KP SCAL's performance to a higher star rating than current performance. The most appropriate annual target for the composite measures is determined by a Clinical Strategic Goals (CSG) Planning committee. The AQC Score allows each Area to focus and prioritize based on their performance on specific measures relative to the gap to the measures' targets. In fact, the Ambulatory Quality Composite Score is designed such that no single specialty or group of physicians can improve all, or even most, components of the composite. Performing well on the composite requires a team effort involving the entire medical center. One of the new features of the 2022 Clinical Quality Key measures is the inclusion of an inter-area interdependence goal: the proportion of Areas that are meeting the AQC target. Our goal is to have all 13 service areas meeting the target by the end of the incentive cycle as everyone benefits when all are successful.

The 2022 Clinical Quality Key Measures include measures to promote health through tobacco cessation management, adult weight management and immunizations for flu prevention. The

Tobacco Cessation Management (TCM) measure is the percentage of smokers who attended coaching or a class on smoking cessation or who took medications to quit (additional details may be found in the TCM report). The Tobacco User Prevalence measure is a new measure developed with input from the key regional stakeholder groups. The Tobacco User Prevalence measure replaces the Tobacco Quit Rate measure in assessing the outcomes of the efforts around tobacco cessation management.
The Weight Management Program Encounter metric promotes increased participation in weight management programs and an increase in the number of encounters per member to promote sustained weight loss among members who are obese. The measure is based on the count of weight management program encounters by members (ages 18 and older) who are obese (BMI ≥ 30) or overweight (BMI ≥ 25) pre-diabetic (HbA1c ≥ 5.7) per 100 members (obesity at any time during the last 5 years; additional details may be found in the Adult Weight Management (AWM) report).

Flu immunization of members six months and older continues to be a priority from prior years, and our focus for 2022 will be on the flu vaccination rates among African American adult members (18 to 64 years of age). The overall rate will continue to be monitored, but our 2022 target specifically addresses known inequities. Enhancing access opportunities for flu vaccination could be a key factor to attain this target.

Management of our members who suffer from diabetes and hypertension have been areas of focus, and we again commit to addressing inequities. Our goal will be to provide equitable care (instead of just 'equal' care) for our members with diabetes who are part of the Hispanic/Latino population, and for our members with hypertension who are part of the African American population.

The reduction of unnecessary readmissions continues to be important work and a focus for KPSC. However, the Plan All-Cause Readmissions measure has been kept off this list for another year until we have external benchmarks with the latest specifications changes.

2022 Clinical Quality Key Measures	Target
Ambulatory Quality Composite (AQC) Score (Area-specific)	100.0
Proportion of Areas meeting AQC Target	13/13
Being Healthy	
Tobacco Cessation • Tobacco Cessation Management • Tobacco User Prevalence	 40.0% <=4.90%
Adult Weight Management (AWM) • AWM Program Encounters	 32.0
Equitable Care	
HbA1c < 8.0% - Hispanic/Latino Population (18-<65 y/o)	56.0%
Controlling High Blood Pressure – African American Population (18-<65 y/o)	73.0%
Flu Vaccination Rate – African American Population (18-<65 y/o)	45.0%

Patient Safety

Patient Safety is an integral part of the Kaiser Permanente Southern California's health care delivery system. Patient Safety continues to be an important component of all Kaiser Permanente quality improvement programs. Kaiser Permanente has a number of systems in place to reduce the possibility of error, which include the following:

- Selective practitioner hiring processes, as well as ongoing evaluation, education, and review of the care our practitioners who provide care to our members.
- Electronic Pharmacy computer programs that contain information to improve efficiency and help reduce the incidence of adverse drug reactions.
- Tracking systems, such as our breast cancer tracking system and Prostate Specific Antigen (PSA) screening program, to help timely identification of and appropriate follow-up on patients with abnormal mammograms and prostate biopsies.
- Reporting systems to help us identify potential problems so we can prevent them from occurring in the future.
- Safety and a culture of safety programs designed to share and spread our reliable accepted patient-safety best practices and prevention strategies with all medical staff and direct care staff.
- Use of simulation technology with medical staff and licensed and non-licensed healthcare staff to participate in high risk scenario practices to prevent harm to our members.
- Medication programs that include ongoing training of physicians and staff in safe medication processes.
- Intensive systematic educational programs and timely reminders for all staff on patient safety.
- Case rounds with medical staff and leadership, managers and staff on potential patient safety issues.
- Education of physicians and staff on human factor learning and its effect on patient safety.
- Involving our members and educating our members about their role in preventing errors in their health care.

For more information on the Patient Safety program at KPSC reach your regional or local Director of Risk Mgt & Patient Safety. To increase physician and employee knowledge of our safety efforts, Kaiser Permanente organizes and prepares multiple patient safety seminars, training and educational sessions throughout the year.

Medicare Information

Kaiser Permanente California Medicare plans earned 5 out of 5 stars again for the 2023 plan year, the highest overall rating for quality and service, from the Centers for Medicare & Medicaid Services[2].

[2] Every year, Medicare evaluates plans based on a 5-Star rating system.

Kaiser Foundation Health Plan feels it is important that you are aware of key updates impacting our Medicare health plan offerings and Medicare members. Key highlights for the 2023 plan year include:

- We are not making any changes to our SCAL service area for Medicare Advantage for the 2023 contract year.
- The following benefit changes will take effect for **2023 KPSA individual plans**:
    - Implementation of a 20% coinsurance for certain Part B clinically-administered drugs. This change to a 20% coinsurance will make the coinsurance rate for these services more consistent across Kaiser Permanente's regions. It will also be consistent with the coinsurance rate Medicare beneficiaries with Original Medicare coverage have for these services.
    - Increased the eyewear allowance in the base coverage to either $100 or $300 depending on the plan.
    - Added a hearing aid allowance in the base coverage of either $500 or $2,500.
    - Added an Over-the-Counter (OTC) benefit limit of either $50 or $120 per quarter to purchase OTC items from our vendor catalog.
    - Decreased DME and P&O coinsurance from 20% to 10% for certain plans.
    - Under our Advantage Plus package, we increased the hearing aid allowance from $350 to $500 and decreased the eyewear allowance from $340 to $280.

Regulatory requirements
As required by Medicare regulations and as outlined in your contract with Kaiser Permanente, providers are prohibited from collecting cost-sharing for Medicare covered services from members dually enrolled in the Medicare and Medicaid programs. This requirement also applies to individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program, a program that pays for Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Accordingly, it is imperative that you take steps to avoid inappropriate billing/collection of cost-sharing from dual eligible beneficiaries, including QMB enrollees. Kaiser Permanente's contract with the Medicare program requires that we actively educate contracted providers about this requirement and promptly address any complaints from dual-eligible beneficiaries/members alleging that cost-sharing was inappropriately requested or collected. If you have questions regarding a Kaiser Permanente member's eligibility status, please contact the Kaiser Permanente Membership Services Contact Center at (800) 464-4000.

Kaiser Permanente is required to follow the federal requirements established by the Centers for Medicare & Medicaid Services (CMS) for notifying impacted members of provider contract terminations – specifically, we must make a good-faith effort to provide at least 30 days advance notice of a network change. Additionally, we are required to notify CMS of any significant, no-cause provider terminations at least 90 days prior to the effective date.

Medi-Cal and State Programs

If you have any questions regarding this information, please contact the Medi-Cal State Programs department:

Email: Medi-Cal-State-Program@kp.org
Phone: (626) 405-7955 (Tie line: 8-335-7955)

To speak with a consultant regarding Medi-Cal benefits please call the KP Benefits Hotline at (626) 405-3175 or email the KP Benefits Helpdesk at HPRS-BENEFITS-UNIT@kp.org. For information on the current list of preventive services "A" and "B" recommendations from the United States Preventive Services Task Force (USPSTF), please visit their website at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

As a Medi-Cal Managed Care Plan, Kaiser Foundation Health Plan, Inc, and its contracted providers shall comply with all applicable requirements specified in the Department of Health Care Services (DHCS) contract and subsequent amendments, federal and state laws and regulations, and DHCS Medi-Cal Managed Care Policy Letters and All Plan Letters.

Providers for KP's Medi-Cal members must ensure that all medically necessary covered services specified in the DHCS contract are available and accessible to all Medi-Cal members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or group defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

Medi-Cal Program Benefit Updates/Changes

- **Community Supports (CS):** KP provides these services as a substitute to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. For a complete list of CS visit: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-CS-a11y.pdf

- **Enhanced Care Management (ECM):** A Medi-Cal managed care benefit addresses clinical and non-clinical needs of high-need, high-cost individuals through coordinated services and comprehensive care management. ECM services are interdisciplinary, team-based, high-touch and person-centered. For more information on ECM populations of focus visit: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf
  For more details refer to the Care Coordination and Case Management section.

- **Long Term Care Carve-In** for Kern County starts Jan. 1, 2023.

- **Doula Services:** As of Jan. 1, 2023, Medi-Cal members will be notified, likely by letter, of the benefit after the first trimester.

- **Community Health Worker:** Services will become available Jan. 1, 2023.

- **Street Medicine Medical Services:** Services will be available for unsheltered members no earlier than Jan. 1, 2023.

- **Major Organ Transplant Carve-In:** Since January 1, 2022, members approved for Bone Marrow Transplant or Major Organ Transplant, including multi-organ transplant, are no longer disenrolled from KP Medi-Cal. KP is responsible for authorizing and coordinating transplant services for adults (21+), Whole Child Model children, and children requiring transplant services that are not covered by California Children's Services (CCS). CCS remains responsible for authorizing and coordinating transplant services for CCS-approved children, though they will no longer be required to disenroll from KP Medi-Cal upon transplant authorization. Providers or their clinic staff should

contact the Transplant Coordinator for their facility for assistance with transplant services, or the Transplant HUB at 1-323-783-5140.

- **DHCS Mandatory Managed Care Enrollment (MMCE):** 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.

Medi-Cal Requirements Refresher

COVID-19

DHCS has implemented many Medi-Cal changes due to COVID-19, including adding new requirements and providing new flexibilities for providers and managed care plans. For additional information, including DHCS updates released under APL 20-004 and APL 20-011, please see https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx

Behavioral Health: KP is responsible for the delivery of behavioral health services to Medi-Cal members with mild to moderate levels of behavioral health impairment as outlined in APLs 21-006, 21-014, 22-003, 22-005, and 22-006. Members may be managed by Primary Care within provider scope of practice or KP Behavioral Health as appropriate. Primary Care providers may refer Medi-Cal members to KP Behavioral Health; additionally, Medi-Cal members may self-refer to KP Behavioral Health. Medi-Cal Managed Care members are referred by KP Behavioral Health to the local county mental health department for specialty services, including inpatient and outpatient specialty mental health services for members with more acute to severe behavioral health issues, and to the County addiction programs for suspected substance use disorders. KP Behavioral Health assesses Medi-Cal members to assess their level of treatment need and refers to County programs based on symptoms, diagnosis, and medical necessity. Providers should contact their local KP Behavioral Health departments for assistance with Medi-Cal members' behavioral health needs. Referral process to county behavioral health programs, including County and community substance use disorder treatment programs, may vary by facility and county.

Bridge To Treatment: KP SCAL Emergency Departments (ED) participate in the Bridge to Treatment Program. Navigators funded with Bridge to Treatment grant dollars work with ED clinical teams to identify, ensure clinically appropriate MAT administration and/or prescribing, along with referrals to County and community-based providers for ongoing substance use disorder treatment and recovery support services.

Behavioral Health Treatment/Applied Behavioral Analysis: KP covers medically necessary Behavioral Health Treatment (BHT) / Applied Behavioral Analysis (ABA) services for Medi-Cal members under 21 years of age, regardless of autism spectrum disorder (ASD) diagnosis, based upon medical necessity determined by a licensed physician and surgeon or a licensed psychologist. KP's BHT services align with APL 19-014.

Blood Lead Screening: Kaiser Permanente ensures that its Network Providers (i.e. physicians, nurse practitioners, and physician's assistants), who perform periodic health assessments (PHA) on child members between the ages of six months to six years (i.e. 72 months), comply with current federal and state laws and industry guidelines for health care providers issued by the Childhood Lead Poisoning Prevention Branch (CLPPB), including any future updates or amendments to these laws and guidelines. Kaiser Permanente ensures that its Network Providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child

that at a minimum, includes information that children can be harmed by exposure to lead especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance is provided at each PHA, starting at 6 months of age and continuing until 72 months of age. Perform blood lead screening tests on all child members in accordance with the following:

- At 12 months and at 24 months of age.
- When the Network Provider performing PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
- When the Network Provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken when the child was 24 months of age or thereafter.

California Children's Services (CCS): KP must facilitate identification and referral of children with certain, eligible conditions to California Children's Services. Once identified and referred, all medical care, diagnostic services, hospitalizations, and any durable medical equipment associated with the CCS condition are covered by the CCS program. Only care related to the CCS condition is carved out of coverage; all primary care and care not related to the CCS condition remains the responsibility of KP. KP continues to provide all medically necessary covered services for the member's CCS eligible condition until the local county CCS Program confirms CCS eligibility by generating an authorization. If a physician identifies a Medi-Cal member under the age of 21 with a CCS-eligible condition, the physician must notify their regional CCS coordinator immediately to ensure timely submission of the referral to the CCS program. CCS-eligible conditions include chronic medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, congenital heart defect, cancer, etc.; a brief summary list is available at www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx

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

Claims and Encounter Data Submission

Periodic reporting of encounter data is a requirement for Medi-Cal managed care providers. Contracted providers must ensure the complete, accurate, reasonable, and timely submission of claims and encounter data to KP. KP encourages the electronic submission of claims and encounter data. Please contact the Southern California KP EDI Support team at EDISupport@kp.org if you have questions about the electronic submission.

Durable Medical Equipment (DME) Coverage

Medi-Cal coverage for DME may cover some items not usually covered by other insurance or Medicare. Examples include incontinence supplies, shower benches, and some types of wheelchairs. In addition, there are guidelines for how often a member may receive certain items. For members with Dual coverage, their primary coverage may cover some of the above items; Medi-Cal is the payer of last resort. Please contact KP's Member Service Contact Center at (800) 464-4000 for assistance with Medi-Cal DME benefits.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Coverage
Under the EPSDT program, for children under the age of 21, KP must provide comprehensive screening, vision, dental, and hearing services at intervals that meet standards of medical/dental practice. KP must provide any medically necessary as well as other necessary health care, diagnostic services, treatment, and measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Kaiser Permanente provides and covers all medically necessary EPSDT services, unless otherwise carved-out of the Kaiser Permanente contract with DHCS, regardless of whether such services are covered under California's Medicaid State Plan, when the services are determined to be medically necessary. While dental services are carved out of the Medi-Cal Managed Care contract, KP must provide dental screenings during the Initial Health Assessment (IHA) and during periodic assessment. KP is responsible to ensure members are referred to appropriate Medi-Cal dental providers, and for the provision of covered medical services not provided by dentists or dental anesthetists (may require prior authorization).

EPSDT services include the provision of medically necessary BHT services to members under 21 years of age, to minimize behavioral conditions and promote member function, to the maximum extent practicable. Members ages 18-21 are also eligible for additional screening for Alcohol Misuse: Screening and Behavioral Counseling under EPSDT benefits.

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

KP's cultural competency training is available through the community provider portal. For more information, please go to:
https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/scal/ever/diversity-cultural-competency-cultural-sensitivity-training-booklet-sca-en.pdf

KP is committed to providing equal access to our facilities and services for people with disabilities. This includes full compliance of the Americans with Disabilities Act (ADA), federal, state, and regulatory requirements in making all facilities, services, and programs accessible in a timely and effective manner.

Ethical/Religious Objections
Practitioners are not required to perform, or otherwise support, referrals and/or coordination of covered services to which the practitioner has a religious or ethical objection. KP shall evaluate these situations to arrange, coordinate, and ensure the timely provision of services through other means.

Initial Health Assessment (IHA)
New Medi-Cal members must have an Initial Health Assessment (IHA) within 120 days of enrollment in Medi-Cal. KP makes at least 3 attempts to contact new Medi-Cal members to

schedule the IHA. Primary Care Physicians (PCPs) are responsible for fulfillment of all requirements of the IHA, which consists of the following elements:

- Comprehensive history, including present illness, medical and social history, and review of organ systems
- Preventive services per clinical recommendations applicable to the member's age, gender, and health status (American Academy of Pediatrics (AAP) and Child Health Disability Prevention (CHDP) for children/adolescents; American College of Obstetricians and Gynecologists (ACOG) for women/perinatal; USPSTF and Centers for Disease Control (CDC) for all populations)
- Comprehensive physical and mental status exam, and dental/oral health assessment; includes alcohol misuse screening
- Diagnosis and plan of care, including follow-up
- Administration of the age-appropriate Individual Health Education Behavioral Assessment (IHEBA)

The current list of preventive services "A" and "B" recommendations is available at the USPSTF website: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Managed Long Term Services and Supports (MLTSS)

KP is required to coordinate MLTSS. MLTSS encompasses several services: Community-Based Adult Services (CBAS), Long Term Care (LTC), Multi-purpose Senior Support Programs (MSSP), and In-Home Supportive Services (IHSS). If you identify a KP Medi-Cal member who may be eligible for any of these MLTSS services, please contact the Regional Complex Care Management Department at (866) 551-9619 (TTY users call 711) for assistance. Department staff are available Monday through Friday from 8 a.m. to 5:30 p.m. For Special Needs Plan (SNP) members, please contact the local Special Needs Plan Team (page 15).

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. Most providers enroll in Medi-Cal through the DHCS enrollment unit. Alternately, some Medicaid Managed Care (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

Grievances must be submitted orally or in writing within 180 days of the incident resulting in dissatisfaction.

Provider Medi-Cal Training

The state of California requires that new providers to KP (employees or contractors) complete training on aspects of Medi-Cal within 10 working days of hire. Newly contracted providers may access the Provider Quick Reference Guide, "Benefits and Services for Kaiser Permanente's Medi-Cal Managed Care Members," on KP's Community Provider Portal: http://providers.kaiserpermanente.org/info_assets/cpp_sca/Contracted-Provider-Quick-Reference-Guide-to-Medi-Cal-Managed-Care-Program-FINAL-July-2021.pdf. If you have any

questions about the provider training on Medi-Cal, please contact the Medi-Cal State Programs team at Medi-Cal-State-Program@kp.org, for more information.

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

For more information about PPCs, including a list of reportable conditions, please refer to the DHCS website: http://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx. After discovery of a PPC and confirmation that the patient is a Medi-Cal beneficiary, the provider caring for the patient must report the PPC to the DHCS though the following link: https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx. KP must also be notified of any PPC reported to DHCS for our assigned Medi-Cal members. Please fax a copy of the completed DHCS form to 626-683-2087, ATTN: Director of Risk Management Patient Safety to notify KP of a PPC.

Provider Network Changes and Terminations
KP is required to notify DHCS of any termination to KP's provider network that constitutes a change in the availability or location of covered services for Medi-Cal members. Additionally, 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 program.

Punitive Action Prohibitions
KP may not take punitive actions against a provider who either requests an expedited resolution or supports a Member's appeal. KP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

- 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
- For 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.

Transportation Services
Kaiser Permanente covers non-emergent medical transportation (NEMT), and non-medical transportation (NMT) for Medi-Cal members, in addition to emergency medical and non-emergency ground/air ambulance.

- Non-Emergent Medical Transportation (NEMT): Available to Medi-Cal Assigned members requiring covered non-ambulatory door-to-door non-emergency medical transportation services for whom traditional means of private or public transportation is medically contraindicated by the member's medical or physical condition. Medical necessity must be confirmed by a KP-MD or Plan Provider for a Medi-Cal member to

receive NEMT services. KP's SCAL Regional Medical Transportation HUB at 1-877-227-8799 can provide transport coordination assistance for pre-authorized services.

- Non-Medical Transportation (NMT): Available to all Medi-Cal Assigned members requiring ambulatory curb-to-curb transportation to and from health care services covered by KP and/or Medi-Cal (includes Denti-Cal). Unlike NEMT, there does not need to be a medical necessity for NMT, just a need for transportation and the member has no other options. Providers or their staff may direct the Medi-Cal member to call KP Transportation Services at 1-844-299-6230, TTY services dial 711.
- Travel and Lodging: covered for Medi-Cal 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 treat within a reasonable time. Call the travel and lodging coordinator at 626-405-6162.
- Medi-Cal members may also contact the Member Services Contact Center (MCSS) or Local Member Services (LMS) for assistance with questions regarding NEMT or NMT benefits.

Appointment Standards

Kaiser Permanente Southern California (KPSC) has appointment standards against which performance in providing accessibility to outpatient services is measured. In addition, the California Department of Managed Health Care (DMHC) has established Timely Access Regulations (effective January 17, 2011). All KPSC appointment standards meet or exceed the minimum requirements of the DMHC regulations.

Under California State law, health plans, including Kaiser Permanente, must evaluate the availability of provider appointments. Your contract with Kaiser Permanente obligates you to cooperate with activities related to the maintenance of regulatory compliance, and these include participating in the DMHC and the Department of Health Care Services (DHCS) Provider Appointment Availability Surveys. If you are selected to participate, you will be asked about your next available urgent and non-urgent appointments, to ensure compliance with provider availability and wait time standards.

The continuous monitoring and improvement of access performance is a major focus for the organization and help focus improvement efforts to move toward the goal of an exceptional care experience for all members. Please contact the Regional Service and Access department at (626) 405-6209 for more information on access initiatives.

APPT CATEGORY	DEFINITION	KP INTERNAL STANDARD
SPECIALTY DEPARTMENTS		
Consult	Physician or member-initiated appointment for an initial assessment by a specialist. a. Consult	10 Business days
	b. Prenatal New	
	c. Routine Behavioral Medicine (non-MD)	

APPT CATEGORY	DEFINITION	KP INTERNAL STANDARD
	d. Optometry Routine	
Follow-up	a. An appointment for which the doctor has asked the patient to return in 8 weeks or less.	a. 5 Business days
	b. Behavioral Health: Non-urgent follow-up appointments with a non-MD mental health care or substance use disorder provider must be offered within 10 business days of the member's prior appointment.	b. 10 Business days
Routine (Includes Center for Healthy Living)	An appointment for which the doctor has asked the patient to return in more than 8 weeks or a member-driven appointment.	15 Business days
Procedure (Category name is indicated in parentheses, if different)	An appointment for a clinical procedure or treatment. a. Diagnostic Procedure, Symptomatic Gastro Procedure (Procedure 14)	a. 10 Business days
	b. Routine Procedure (Procedure 30)	b. 22 Business days
	c. Routine Gastro Procedure (Procedure 90)	c. 64 Business days
	d. Diagnostic Radiology (CT, MRI, Ultrasound, Mammogram)	d. 15 Business days
PRIMARY CARE		
Adult Primary Care (APC): **Routine** **Non-urgent**	Non-urgent routine appointments	7 Business days
Pediatrics: **Routine** **Non-urgent**	Non-urgent routine appointments	5 Business days
APC and Pediatrics: **Preventive**	Physicals, Teen Physicals, Well Baby, and Pap Smears	15 Business days
Follow-up	Follow-up care for an initial acute or chronic problem needing episodic follow-up that has not reached a maintenance state or been resolved. Appointment requests in 8 weeks or less from last visit.	5 Business days
URGENT & EMERGENT (ALL DEPARTMENTS)		
Urgent	Clinical problems which are neither emergent nor routine (includes same day, walk in, acute care) a. Urgent	a. 48 hours
	b. Urgent Behavioral Medicine: A behavioral health crisis that is not deemed to be emergent, but symptoms demonstrate	b. 24 hours

APPT CATEGORY	DEFINITION	KP INTERNAL STANDARD
	impaired ability to function in normal roles at home, work, or school	
Emergent (NOT an appointment category; used here for the purposes of defining the standard)	Sudden, unforeseen illness or injury that requires immediate medical attention - or which, if left untreated, could result in serious disability or death **Psychiatry:** A behavioral health life-threatening or non-life-threatening crisis that may result in a danger to self or others or concern of further decompensation (e.g. intra-psychic or environmental) **Addiction Medicine:** May include components of a medical or psychiatric emergency	Immediate

**Standards include provisions for appropriate backup for physician absences.

Timely access to care is an integral part of the Kaiser Permanente Southern California's health care delivery system and we are committed to offering members timely access. If a Member or a Provider has a complaint regarding timeliness of referrals, the Member or Provider may contact the Member Services Department at any of our local facilities or at the Member Services Contact Center at (800) 464-4000.

If a Member's plan is regulated by the DMHC, the Member or a Provider may file a complaint with the DMHC regarding timeliness of referrals. Providers may file a complaint by contacting the DMHC's provider complaint line at (877) 525-1295.

Service and Access Quality Goals

Kaiser Permanente's ongoing goal is to constantly improve our members' care experience. Kaiser Permanente conducts various member and patient care experience surveys to evaluate our members' satisfaction with access and their care.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) – assesses member care experience and satisfaction with KP as a health plan on an annual basis at the regional level; results are reported publicly.
- California Patient Assessment Survey (PAS) – evaluates patient experience with care from their primary care provider (PCP) or specialist at the medical group level on an annual basis; results for each KPSC medical center area are reported as if it were its own medical group. Additionally, all 13 KPSC area results are reported publicly.
- Member Experience Tracking Evaluation and Opinion Research (METEOR) – is an internal version of CAHPS conducted on a semi-annual basis and reported at the region and medical center area level on an annual basis to monitor our performance on strategic service goals as well as to anticipate our performance on CAHPS.

The results from all of the surveys are used to identify our strengths and opportunities, and to strategically set our performance goals.

CAHPS and Other Service Assessments

The National Committee for Quality Assurance (NCQA) began requiring health plans to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) each year as part of the NCQA accreditation process. CAHPS standardizes the measurement of member perception across health plans. The results are important not only for NCQA accreditation, but to set KPSC service improvement goals and to compare member experiences with health plans across the nation.

The latest KPSC CAHPS results and National and Pacific percentile rankings from the 2022 Quality Compass were publicly released in the summer of 2022. These results will be used to evaluate opportunities for improvement and guide strategic service and access (care experience) goals for the 2023 performance year.

	2022 KP-SCAL Score	**2022 KP-SCAL National Percentile** Ranking	**2022 KP-SCAL Pacific Percentile** Ranking
Overall Ratings			
Rating of All Health Care (%9+10)	**47.76%**	**25th**	**50th**
Rating of Health Plan (%9+10)	**50.91%**	**75th**	**75th**
Rating of Personal Doctor (%9+10)	**63.24%**	**10th**	**33rd**
Rating of Specialist Seen Most Often (%9+10)	**65.84%**	**33rd**	**50th**
Composite Measures			
Getting Needed Care Composite	**74.10%**	**<5th**	**10th**
Getting Care Quickly Composite	**67.60%**	**<5th**	**5th**
Personal Doctor Communication Composite	**90.41%**	**<5th**	**5th**
Claims Processing Composite	**NA**	**NA**	**NA**
Care Coordination	**76.79%**	**<5th**	**10th**
Customer Service Composite	**87.05%**	**10th**	**50th**

For the 2022 performance year, 2021 CAHPS and PAS results were used to develop strategic service goals to help us focus our quality improvement efforts. The following 5 measures from CAHPS and PAS were selected based on their importance in improving overall rating of health care:

1. How doctors/providers communicate (CAHPS) – to achieve the external benchmark, 2022 CAHPS Pacific 75th percentile, 96.05%.
2. Getting care quickly composite (CAHPS) – to achieve the external benchmark, 2022 CAHPS Pacific 75th percentile, 82.99%.
3. Getting needed care composite (CAHPS) – to achieve the external benchmark, 2022 CAHPS Pacific 75th percentile, 83.65%
4. Overall rating of specialist (CAHPS) – to maintain the external benchmark, 2022 CAHPS Pacific 75th percentile, 67.29%.
5. Office Staff composite (PAS) – to achieve the external benchmark, 2022 PAS 90th percentile, 80.80%.

Kaiser Permanente monitors and evaluates our progress on the above measures on an ongoing basis using our CAHPS, PAS, and METEOR surveys. The results are communicated to practitioners, providers, employees, and senior leaders via several modes: routine reports, presentations at meetings, and by sharing results posted on the Office of the Patient Advocate health plan and medical group report cards (www.opa.ca.gov) and the NCQA health insurance plan ratings (http://healthinsuranceratings.ncqa.org/).

New Technology

Kaiser Permanente has an established, rigorous process for evidence-based medical technology assessment. The Medical Technology Management Process (MTMP) is a formal function of three entities: the Medical Technology Assessment Team (MTAT), the Medical Technology Deployment Strategy Team (MTDST) and the Regional Product Council (RPC). These entities ensure that decisions regarding the introduction of select new technologies are evidence based; that aspects of quality of care, patient safety, service and cost are considered during the technology planning and implementation process; and that an ongoing management structure for select new and existing medical technologies is in place.

The MTAT, MTDST and the RPC work closely with representatives from SCPMG Chiefs of Service groups, Clinical Technology Committees, and other relevant clinical groups impacted by new technologies to ensure adequate representation from stakeholders in the evidence review and deployment processes. Southern California's Health Plan Benefits and Regulatory Policy reviews MTMP decisions for their impact on Health Plan benefits. On a national or program level, Southern California also participates in the Interregional New Technologies Committee (INTC), which evaluates the evidence basis of new medical technologies of interest to all KP regions.

Please contact the director of the Evidence-Based Medicine Services Unit at marguerite.a.koster@kp.org for additional information on Kaiser Permanente Southern California's medical technology assessments.

Medical Record Documentation

Kaiser Permanente has developed standards for the content, confidentiality, and security of a Member's Medical Record in accordance with HIPAA and California laws/regulations. Kaiser Permanente's Medical Record and office site review standards are generally accepted best

practices throughout the medical community and are designed to comply with NCQA and other regulatory requirements.

Confidentiality of Information:
Safeguarding medical information is basic to the provision of quality healthcare.

- Medical records should be maintained, stored, destroyed and disposed of in a manner that preserves the confidentiality of the information.
- Medical Records are stored securely.
- Only authorized personnel have access to records.
- Staff receives periodic training in Member information confidentiality.
- All information communicated in the course of providing care is confidential.
- Release of medical information, which includes all Member identifiable patient information, is to be in compliance with state and federal law and with KPSC and facility guidelines.
- Procedures and standards are in place to maintain patient confidentiality. In addition to the standards that require KP to protect privacy and security of identifiable health information, Health Insurance Portability and Accountability Act (HIPPA) also provides standards for Electronic Data Interchange (EDI) and National Provider Identification (NPI) numbers

Medical Record Keeping System Requirements:
Medical Records are required to be:

- Organized and stored in a manner that allows easy retrieval and in a secure manner that allows access by authorized personnel only.
- Reasonably available at each Member visit, whether in hard copy or electronic format
- Compliant with the KP policies and procedures and applicable regulatory requirements.
- Uniform in content and format.
- Organized systematically in a way that facilitates data retrieval and compilation.

Other Record Keeping System Requirements:

- Electronic capture and storage of protected health information (PHI) may be implemented to enhance access to patient data by health care practitioners and other authorized users.
- Electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the physician office record.
- If any record contains PHI, it is subject to state and federal privacy laws and those records may only be released in compliance with applicable privacy law. KPSC Release of Information policies and procedures shall be followed.
- The safety and security of the physician office record shall be protected at all times in accordance with state and federal regulations

Medical Record Documentation:

- Documentation in the Hospital Medical Record will comply with Kaiser Permanente policies and procedures, and shall include appropriate patient identification
- The Hospital Medical Record should be uniform in content and format, as applicable to the care or service provided
- Entries must be legible and complete
- Hospital Medical Record entries should be completed at the time the documented services are performed

- Hospital Medical Record entries must include the date and time, and be signed by the author of the entry or electronically identify the author of the entry
- Abbreviations from the “Do Not Use” abbreviation list should NOT be used
- If a documentation error occurs, the Hospital Medical Record must be corrected according to established policy and procedure
- Patients are not allowed to change the original documentation in their Hospital Medical Record. Instead, requests from patients to addend the medical record should be processed according to established policy and procedure
- The qualitative and quantitative analysis of the Hospital Medical Record documentation may be conducted according to Kaiser Permanente policies and procedures
- The Hospital Medical Record contains PHI which may be released only in compliance with applicable state and federal privacy laws and regulations
- The safety and security of the Hospital Medical Record shall be protected at all times in accordance with state and federal laws and regulations

All data recorded by Kaiser Permanente in the medical record and in other systems that store other Member health and enrollment information must be accurate, complete, and truthful.

Please contact KPSC local HIM Director for more information.

Practitioner Credentialing

Kaiser Foundation Health Plan, Inc. (KFHP) provides a systematic and integrated process for the credentialing and recredentialing of Practitioners who provide direct patient care. Practitioners must meet clearly defined criteria and standards. The decision to a grant approval to see health plan members is based upon primary source verifications, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal law. To remain eligible for participation in the health plan network the Practitioners must continue to satisfy all applicable requirements.

Practitioners have the right to review the information submitted in support of their credentialing or recredentialing application and have the right to correct erroneous information in their credentials file. Applicants/Practitioners also have the right, upon request, to be informed of the status of their application and reapplication by contacting the Regional Credentialing Department or the local Medical Staff Office at any time during the credentialing process.

KFHP credentialing standards includes procedures to ensure non-discrimination against a Practitioner for any reason, including but not limited to age, sex, marital status, religion, ethnic background, national origin, ancestry, race, sexual orientation, specialty/training or health disability status. The criteria for Practitioner selection, evaluation, and retention do not discriminate against Practitioners who serve high-risk populations or specialize in the treatment of costly conditions.

When Southern California Permanente Medical Group (SCPMG) or Kaiser Foundation Health Plan and Hospitals (KFHP/KFH) takes an action that is grounds for a hearing, the affected Practitioner shall be entitled to written notice (“Notice of Action”), which states the procedure for a Fair Hearing and includes information about:

1. the action or proposed action;

2. that, if adopted, such action will be reported to the appropriate state licensing agency and, if applicable, the National Practitioner Data Bank;
3. the Practitioner's right to request a hearing;
4. that a Practitioner who chooses to request a hearing, must do so in writing no more than thirty (30) days after Date of Receipt of the Notice of Action;
5. the right to be represented by an attorney or another person of choice;
6. that a hearing officer or a panel of individuals will be appointed to review the appeal; and
7. written notification of the decision that contains the findings and conclusion of the decision.

A Practitioner who wishes to appeal an action or proposed action must deliver a written request for a hearing to the Credentials and Privileging Chair, or as otherwise instructed in the Notice of Action no more than thirty (30) days after the Date of Receipt of the Notice of Action. In the event the practitioner does not request a hearing within such time, he or she shall be deemed to have waived the right to a hearing and have accepted the action and it shall thereupon become the final action of SCPMG and/or KFHP. More information about KPHP's Fair Hearing procedure is available by contacting the Regional Credentialing Department, Credentials and Privileging Chair, or Senior Vice President (SVP).

KP Southern California Quality Program

Health Plan Quality Oversight

Kaiser Foundation Health Plan (KFHP) is responsible for the oversight and monitoring of quality improvement activities. Kaiser Foundation Hospitals (KFH) and Southern California Medical Group (SCPMG) collaborate with Kaiser Foundation Health Plan to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. Together, the three entities operate the Kaiser Permanente Medical Care Program in Southern California.

Quality Program

The Quality Program is approved annually by the Southern California Quality Committee (SCQC) and the Quality and Healthcare Improvement Committee (QHIC), a subcommittee of the KFHP Board of Directors. Documents to include:

1. Quality Program Description (quality structure, authority, key programs, data systems, and improvement methods)
2. Quality Workplan (goals, metrics, and responsibilities)
3. Evaluation of the prior year's Quality Workplan (quantitative and qualitative analysis of results)

The Quality Program Documents are trilogy documents forwarded to Southern California Medical Centers for implementation at the local level.

Additional Information

Contracted providers and practitioners can obtain an electronic copy of Kaiser's Quality Program Description by contacting the Regional Quality Department at SCAL-Quality-and-Regulatory@kp.org.

SCPMG practitioners can learn more about the Quality Program by contacting the local Quality Department and requesting a copy of the Quality Program Description.

Members can review Kaiser's quality program and obtain sources of additional information from:

- Kaiser Member Guidebook (published annually for each medical center)
- KP.ORG

NCQA Accreditation

The National Committee for Quality Assurance (NCQA) has accredited the Kaiser Foundation Health Plan (KFHP) Southern California. NCQA is an independent, non-profit organization whose goal is to improve the quality of health care. The NCQA accreditation process evaluates how well the health plan manages the delivery of health care and services with the goal to continuously improve health care. Accredited health plans face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn NCQA's seal of approval.

The last accreditation survey for the KFHP was conducted in April 2020 for which the Commercial and Medicare HMOs received an "Accredited" status. Kaiser Permanente met or exceeded NCQA's strict evaluation and rigorous requirements in the areas of quality, utilization management, preventative measures, member services, physician credentialing and improvement initiatives. The next NCQA Health Plan accreditation survey will take place in March 2023.

The **NCQA Patient-Centered Medical Home (PCMH)** standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication, and patient involvement. PCMH promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions based on the fullest understanding of information in the context of a patient's values and preferences. KPSC currently has 105 recognized practice sites.

NCQA's PCMH model focuses on providing personalized, comprehensive and evidence-based medical care using a physician-led team of professionals. SCAL primary care medical office buildings function as Medical Homes; any patient visiting their primary care physician is inherently being managed by a team to improve their quality and overall care experience.

Kaiser Foundation Health Plan has achieved NCQA's **Multicultural Health Care Distinction (MHC)**. This achievement demonstrates the excellence of Kaiser's Diversity program. Specifically, the distinction is focused on the following five categories: Race/Ethnicity and Language Data, Access and Availability of Language Services, Practitioner Network Cultural Responsiveness, Culturally and Linguistically Appropriate Services Programs, and Reducing Health Care Disparities.

More information about NCQA may be found at http://www.ncqa.org/ or by contacting the Southern California Quality and Regulatory Services Department through e-mail at SCAL-Quality-and-Regulatory@kp.org.

Thank You
Thank you for your attention to these policies, processes and practices and for serving Kaiser Permanente members and patients.

Southern California Special Needs Plan (SNP)

Provider Annual SNP Model of Care Compliance Training

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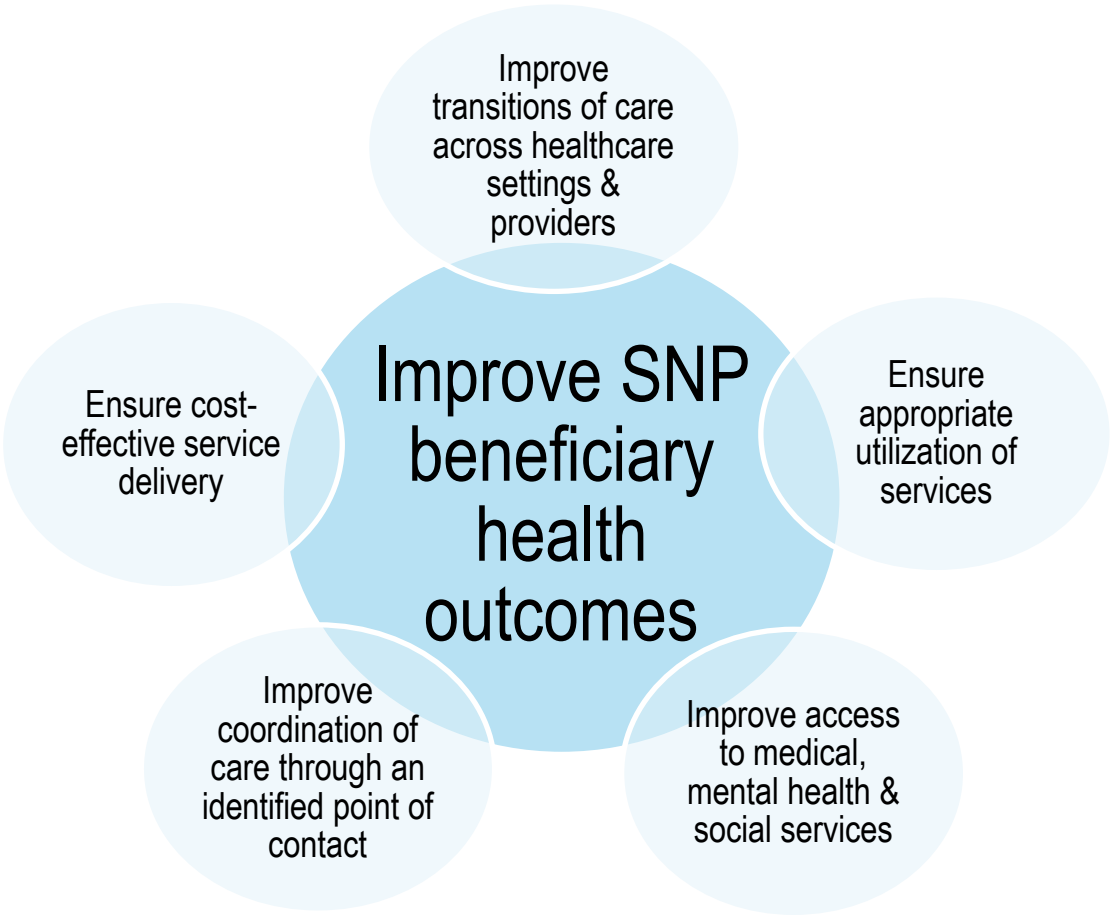
Medicare Advantage Special Needs Plan (SNP)

- SNP is a federal government program established by CMS to provide targeted care to special needs individuals.
- The following are 3 cohorts that CMS identified as special needs individuals:

Type of SNP	Target Population
Institutional SNP (I-SNP)	Institutionalized individuals
Dual Eligible SNP (D-SNP)	Dually eligible for Medicare and Medi-Cal
Chronic Condition SNP (C-SNP)	Individuals with severe or disabling chronic conditions, as specified by CMS

- Kaiser Permanente Southern California (KPSC) only participates in the D-SNP plan

Special Needs Plan Model of Care Goals



Who are KPSC D-SNPs:

- Are Medicare Senior Advantage members with Medi-Cal
- Also known as Medi-Medi members
- KPSC has approximately 30,000 SNP members
- Based on information obtained both from self-reported data in the Health Risk Assessment and through patient clinical history, a SNP member is likely to:

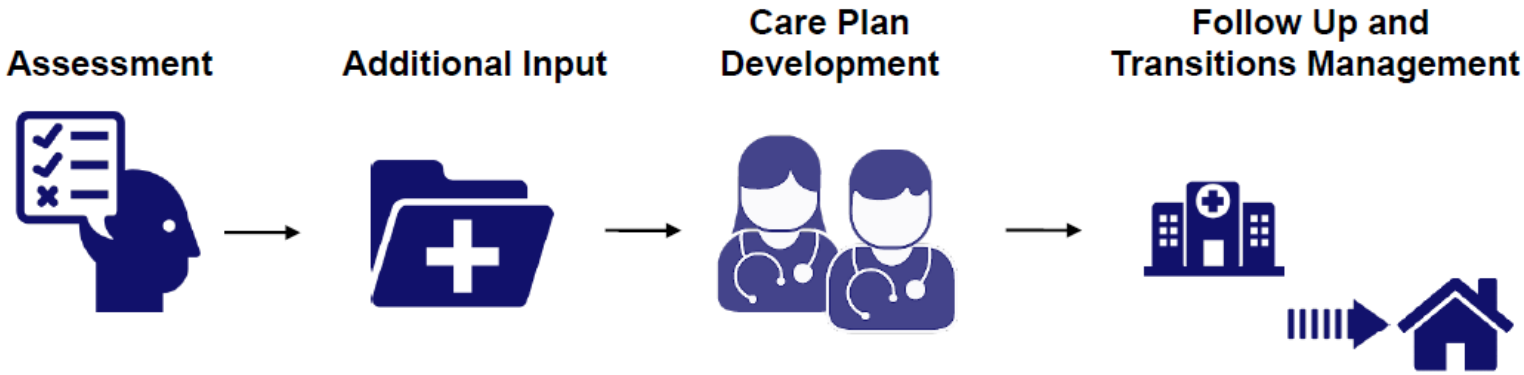
  - Be female (62%)
  - Be Hispanic (26%)
  - Be divorced/separated/widowed (31%)
  - Have a grade school education (14%)
  - Be unemployed (58%)
  - Experience multiple chronic conditions
    - Approximately 74% have at least one chronic condition
    - 20% have 3 or more chronic conditions

Top 10 Diagnosis in the SNP Population:

1. Atherosclerosis of Aorta
2. DM 2
3. Essential HTN
4. GERD (Gastroesophageal Reflux Disease)
5. HTN (Hypertension)
6. Hyperlipidemia
7. Hypothyroidism
8. Osteopenia
9. Osteoporosis
10. Prediabetes

SNP Model of Care Workflow

The Interdisciplinary Care Team (ICT) develops a care plan for each SNP member to support the Clinician and ensure the member's care is coordinated



- Member annually completes a Health Status Questionnaire
- Generates scores used for risk stratification

ICT attempts to collect additional information from the member telephonically and through their Medical Record in KP HealthConnect

ICT develops a Care Plan for member and sends to the Clinician for approval.

- ICT manages member's transitions between settings and updates the care plan, as appropriate
- Intensive case management for high risk members is available

Reporting and Performance Management: As a condition of participation, KP must meet requirements designed to show how well we are working to improve the overall quality of care & service for these patients.

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What is your role?

- Provide medical care to evaluate, diagnose, and treat members' disease/condition(s) (i.e. pain, injury, physical, mental)
- Provide health maintenance, promotion, supportive and restorative care
- To be the members' advocate
- Primary care providers are members of the Interdisciplinary Care Team (ICT)
- Primary care providers review, edit, and accept care plan changes as appropriate via Kaiser Permanente HealthConnect (KPHC) inbox
- Specialty care providers may be asked to participate in the care coordination of the patient
- Per Medicare guidelines, all KPSC providers must complete the annual SNP Model of Care training
- The SNP Care Team will contact the PCP for orders or other needs identified for the members, and is required to communicate care plan updates as appropriate

Why SNPs are established:

- Improve coordination and continuity of care
- Enhance benefits by combining those available through Medicare and Medi-Cal
- SNP patients are assigned to an Interdisciplinary Care Team (ICT) to manage care
- Who are the ICT members?

  - PCP
  - Treating/Specialty Provider
  - SNP Member/Authorized Caregiver
  - SNP Care Manager
  - LTSS Case Manager
  - Pharmacist
  - Behavioral Health Providers
  - Other providers as appropriate, such as Dementia Specialist

