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, confidentiality notices, and agreements. All practitioners and providers with whom Kaiser Permanente 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 available for download here 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. Please refer to the following Medi-Cal and State Programs sub-section: Member Rights and Responsibilities.

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 a 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 at 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 Equity-Inclusion-Diversity-SCAL-HI-Rgnl@kp.org.

Access to Care Decisions, Utilization 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. 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 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).

Pertinent clinical information supporting the requested health care services are obtained and reviewed. Appropriately licensed health care professionals supervise all UM decisions. A licensed physician reviews all full and partial denials of a health care service when the determination is based on medical necessity. The criteria used in the UM review process are available to all practitioners upon request at no cost. UM oversight is invoked in a small minority of medical decisions and is based on objective criteria or guidelines used in conjunction with clinical judgment. For further information about Kaiser Permanente's UM process, please see http://www.kp.org/um.

UM decision making process, 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 (see Prior Authorization List and Utilization Management Criteria).

    - **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.

[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.

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 [Medi-Cal: (855) 839-7613], 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, 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

UTILIZATION MANAGEMENT GUIDELINES AND CRITERIA	
SERVICE Requiring Prior Authorization	**GUIDELINES**
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
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 Compliance 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 [Medi-Cal: (855) 839-7613] 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, 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 is embedded within KP HealthConnect™. The Proactive Care Checklist serves as an invaluable resource for frontline healthcare teams to identify and address specific care gaps for each patient. Tailored to individual patients, these checklists consider factors such as age, gender, medical history, and existing conditions. Proactive Care Checklists are crafted to compile pertinent information that can be readily acted upon, aiding in the management of both preventive and chronic care requirements. Regardless of your department, your role in closing these care gaps with patients is essential. Opportunities to engage with our patients present themselves across all care settings, including during Telehealth Appointments (TAVs) and Video Visits.

Proactive Panel Management simplifies patient care oversight by aiding administrative users, frontline staff, and physicians in identifying and evaluating individuals with actionable care gaps. Customized recommendations are subsequently offered to bridge these gaps, with particular emphasis on patients who may not actively seek face-to-face care. Our panel management tool empowers users to generate focused queries for specific patients or necessary actions.

Centralized Outreach uses an advanced infrastructure for efficiently coordinating centralized, actionable, and standardized online and outbound mass communications to our members. This effort, supported by experienced consultants, aims to improve clinical quality and outcomes. Centralized coordination ensures strategic and cohesive efforts are documented within each patient's HealthConnect chart, maximizing resource utilization, and ensuring uniform message dissemination. Our communications provide practical steps for proactive health management, enhancing member engagement. Standardizing outbound communications ensures quality, reliability, and cost-effectiveness, fostering trust among members. Through these efforts, we aim to drive significant improvements in clinical quality and outcomes across our community.

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, reducing readmission rate, and improving patient quality of life. This combines inpatient care management, post discharge follow-up, and outpatient care management to provide improved access to care, timely assessment and intervention to reduce risk of readmission.

Medication Adherence incorporates healthcare professionals, including physicians, pharmacists, and nurses, provides medication therapy, education, and drug information to patients. They use evidence-based guidelines and standardized practices to optimize medication effectiveness and improve clinical outcomes. Clinicians identify barriers and offer solutions to help patients use medications correctly. Patients overdue for refills or with low adherence rates, receive phone outreach, secure kp.org messages, and letters in the mail reminding them to refill the outstanding medications.

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 is a patient-facing application available on kp.org and KP HealthConnect™, aimed at empowering patients to manage their care gaps efficiently through various communication channels. Key objectives include providing easy-to-understand information about care gaps, facilitating actions to address them, delivering test results directly, and educating patients on health options. Currently covering 99.99% of Southern California membership, oPAP has evolved into a comprehensive self-management portal, offering personalized content and specialist topics. It serves as an effective means of patient engagement without necessitating frequent office visits.

Clinical Quality: The CCSP Clinical Quality Consultant's mission is to provide clinical support and guidelines, as well as facilitate sharing of information and best practices across the medical service areas for select clinical quality programs such as pediatrics, readmissions, behavioral health, Human Immunodeficiency Virus (HIV), Hepatitis C, Clinical Strategic Goals support program, Atherosclerotic Cardiovascular Disease (ASCVD), hypertension, and healthy bones.

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 (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. Members may contact their Primary Care Physician (PCP) to request a referral to a specialty department.

Regional Care Coordination and 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, Members may have:

- Multiple chronic conditions or one complex condition
- Significant deficits in social determinant of health that impact their health
- Difficulty navigating the health care system
- Difficulty managing treatment prescribed by their provider or nonadherence to treatment plans
- Frequent missed appointments with serious medical conditions
- Pattern of utilizing emergency services in lieu of primary or urgent care

RCCCM provides intensive, personalized case management, transitional care services, and service 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 with Medi-Cal coverage including Medi-Cal Seniors and Persons with Disabilities (SPDs), and complex KP Dual Complete (SNP) Members. The RCCCM case managers outreach to members and conduct health risk assessments (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, individuals at risk for avoidable hospital or ED utilization, individuals with serious mental illness and/or substance use disorder (SUD) needs, 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, children and youth involved in child welfare, and children and youth enrolled in California Children's Services (CCS) or Whole Child Model (WCM) with additional needs. Individuals with Intellectual and Developmental Disabilities (I/DD) and Pregnant and

Postpartum Individuals at risk for adverse perinatal outcomes are also eligible. 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. For additional information, please visit the following link: Medi-Cal: Enhanced Care Management, Community Supports, and Community Health Workers - CA (kp.org).

Medi-Cal Transitional Care Services (TCS) provides post-discharge support to all KP Medi-Cal members transitioning from one care setting to another. Support during transitions of care is critical to avoiding poor patient outcomes, especially among at-risk populations. The TCS care team provides an additional layer of support to ensure members complete post-discharge treatment and services, with outreach to members to ensure a follow-up appointment is completed. The team also reviews whether a member may need additional services through ECM, CCM or Community Supports and places any needed referrals. TCS support remains available at least 30 days post-discharge.

The level of TCS support differs for high risk and low risk members, however all Medi-Cal members receive one of these levels of support. In addition to the above description, high risk members are assigned a dedicated TCS care manager who connects with the member post-discharge to answer questions about discharge instructions and assess for any gaps in care. The TCS care manager will ensure the member is connected to all necessary services and connect with the PCP as needed. High risk populations include any members enrolled or eligible for ECM or CCM, patients transitioning to or from SNF, any pregnant members including the 12 months post-partum, patients admitted for or requiring post-discharge mental health or substance abuse treatment, seniors and persons with disabilities (SPDHR), children with special health care needs (CSHCN) and members who qualify for long term supports and services (LTSS). Discharging care teams may also identify patients who would benefit from high-risk post-discharge support and may make a referral to High Risk TCS. Please email TCSRgnlTeam@kp.org for more information.

Beginning in 2025, Kaiser Permanente's markets will use the following plan name for all Dual Special Needs Plans (D-SNPs), Kaiser Permanente Dual Complete. KP is removing the "Senior Advantage" from the D-SNP plan name.

Dual Complete (also known as D-SNP)

Kaiser Permanente (KP) offers a Special Needs Plan (D-SNP) for members who are dual eligible called Dual Complete. Members must have both Medicare and Medi-Cal benefits with Medicare assigned to Kaiser Permanente. Dually eligible persons tend to have complex, high cost, high medical and psychosocial needs. Implementation of the Southern California D-SNP Model of Care is a collaboration between RCCCM and local interdisciplinary care teams, including Dual Complete care management teams that provide seamless benefit integration, affordable, high-quality and efficient care coordination to address the complex needs of Dual Complete members.

The Centers for Medicare & Medicaid Services (CMS) goal for all D-SNP plans is to improve member health outcomes by ensuring:

- Improved access to medical, mental health and social services,
- Better coordination of care,
- Adequate provider network,
- Seamless transition of care through an identified point of contact,
- Appropriate utilization of services,
- Cost-effective service delivery.

D-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, including ECM like 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 D-SNP Model of Care 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 other D-SNP regulatory and process measures).
   - Description of the methodology to measure member satisfaction with the SNP care management 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	855-327-2960
Baldwin Park	877-347-5176	San Bernardino County	866-287-1401
Downey	833-849-0233	San Diego	866-300-0019
Kern	855-327-2958	South Bay	855-327-2961
Los Angeles	855-327-2959	West Los Angeles	855-327-2963
Orange County	877-317-6080	Woodland Hills	855-327-2965
Panorama City	866-331-8042	Regional SNP	855-327-5505

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

Reviewing our goals for the year, our members continue to need our support with their healthcare needs, whether those needs are related to preventive care, acute/chronic care, or behavioral healthcare. We must also recognize that as an organization, we need to continue to address inequities in healthcare and recommit to our efforts to shrink disparities in health outcomes.

Maintaining high performance in most of the clinical measures continues to be an imperative. Our results are published in several venues for publicly reported clinical quality metrics. The list includes: NCQA Commercial and Medicare Ratings; CMS Medicare 5-Star Quality Report; State of CA Report Cards; Covered California (Exchange population); and the Integrated Healthcare Association AMP (Align Measure Perform). Each of these organizations may use different cut points for rating our clinical quality of care, 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 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. We have chosen to continue including the 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 latest Clinical Quality of Care Key Measure set also has sections for Care Coordination and Staying Healthy. The metric of focus for Care Coordination is the HEDIS measure, “Plan All-Cause Readmissions,” and the results will be reported specific to the Medicare Risk population. This is a risk-adjusted utilization measure where our goal is to have fewer “observed” readmissions in comparison to the risk-based “expected” readmissions, referred to as an O/E ratio where lower is better.

Flu immunization continues to be a priority from prior years, and our focus this year will be on the childhood flu vaccination rates and the full set of antigens in “Combo 10” (which includes flu). We will monitor rates among African American infants and toddlers in parallel to the rates among our non-African American infants and toddlers. This measure highlights the importance of all childhood vaccinations for some of our more vulnerable populations of young children and specifically addresses known inequities. Pediatricians and other healthcare professionals in Pediatrics will need to reinforce the message to the parents or caregivers that vaccination is safe and important to reduce the impact to the child of infections.

Management of our members who suffer from diabetes and other cardiovascular conditions continues to be an area 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, even as we address challenges with glycemic control in the overall population. We will also be monitoring adherence to statins medications among our members who take statins.

2024 Clinical Quality Key Measures	Target
Ambulatory Quality Composite Score (Area-specific)	100.0
Proportion of Areas meeting AQC Target	13/133
Care Coordination	
Plan All-Cause Readmissions O/E ratio (Medicare members)	1.03
Staying Healthy	
HbA1c < 8.0% - Non-Latino Diabetes Population (18≤65 y/o)	69.0%
HbA1c < 8.0% - Latino Diabetes Population (18≤65 y/o)	61.0%
Childhood Vaccinations: Combo 10 – Non-AA/Black population	61.0%
Childhood Vaccinations: Combo 10 – AA/Black population	43.0%
Proportion of Days Covered by Medications: Statins (Ages 18-85)	84.0%

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 4.5 out of 5 stars for the 2025 plan year from the Centers for Medicare & Medicaid Services[2].

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 2025 plan year include:

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

- We are not making any changes to our SCAL service area for Medicare Advantage for the 2025 contract year.
- The following benefit changes will take effect for **2025 KPSA SCAL individual plans**:
    - Increased specialty care to $5 for Inland Empire value plan (PBP 081) and San Diego value plans (PBP 082).
    - Increased ER to $140 for all plans, except Inland Empire legacy plan (PBP 015) decreased to $95.
    - Increased MRI up to $225 on all plans, except Los Angeles/Orange legacy plan (PBP 003) decreased to $15, and Inland Empire legacy plan (PBP 015) and San Diego legacy plan (PBP 037) to $0.
    - Increased Inpatient hospitalization copays on some plans, up to $180, except Inland Empire legacy plan (PBP 015) decreased to $0 and Inland Empire value plan (PBP 081) to $75.
    - Increased outpatient surgery to $100 for Ventura value plan (PBP 083) and $20 for Kern Enhanced (PBP 035). Decreased to $40 for Inland Empire value plan (PBP 081).
    - Increased ambulance to $300 for Ventura value plan (PBP 083) and $250 for Los Angeles/Orange value plan (PBP 078) and Kern legacy plan (PBP 036)
    - Increased vision allowance to $250 on all value plans and Kern Enhanced (PBP 035).
    - Maintained OTC benefit limit at 2024 levels, except Inland Empire legacy plan (PBP 015) and San Diego legacy plan (PBP 037) where the OTC benefit limit increased from $50 per quarter to $90 per quarter. SNP plans increased to $200 per quarter.
    - Added fitness as a base benefit for all SCAL plans.
    - Advantage Plus optional supplemental benefits package: maintained hearing aid and vision allowances, and comprehensive dental, removed fitness, and decreasing premium.

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, beginning 1/1/2024 CMS requires that Medicare Advantage (MA) plans members be given 45 calendar days' notice (impacted enrollees) when either a primary care or behavioral health provider terminates their contract for no cause during the contract year.

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

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

Medi-Cal and State Programs

If you have any questions about the Medi-Cal Program, please contact:

Email: Medicaid-PROV-Team@kp.org

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 Managed Care (MMC) members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or group defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

Medi-Cal Requirements, Benefits, & Services

Acupuncture

All MMC Members are covered for acupuncture when medically indicated to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Members can contact KP's contracted provider American Specialty Health (ASH) directly at 1-800-678-9133 (8:00 a.m. to 5:00 p.m. PST) or they can go on the website: http://www.ashlink.com/ for more information.

Alternative Birthing Centers, Certified Nurse Midwives, and Licensed Midwives, Doula Services and Abortion Services (Family Planning Services/Providers)

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

Alternative Birthing Centers (ABC) must be Comprehensive Perinatal Services Program (CPSP) certified to provide obstetrical and delivery services. If a MMC Member is interested in

receiving pregnancy care at a CPSP birthing center, please refer them to OB/GYN for a pregnancy risk assessment. If the MMC Member meets the low pregnancy risk criteria, a referral for prenatal, delivery, and postpartum services may be issued if a CPSP birthing center is located within the MMC Member's County.

KP also provides our MMC Members with access to abortion services, as well as the medical services and supplies incidental or preliminary to an abortion. KP and its Network Providers and Subcontractors are prohibited from requiring medical justification, or imposing any Utilization Management or Utilization Review requirements, including Prior Authorization and annual or lifetime limits, on the coverage of outpatient abortion services. Providers can contact KP's Medi-Cal Member Services at (855) 839-7613 for assistance.

Annual Cognitive Health Assessment

For MMC Members who are age 65 and older, and who do not have Medicare coverage, KP will cover an Annual Cognitive Health Assessment. Providers must complete the DHCS Dementia Care Aware at https://www.dementiacareaware.org/. Training must be completed prior to conducting the assessment, which should be administered as part of a visit. The following tools can be used: General Practitioner assessment of Cognition (GPCOG), Mini-Cog, Eight-item Informant, or Short Informant Questionnaire. Use CPT code 1494F for billing.

Cancer Biomarker Testing

KP covers medically necessary biomarker testing for MMC Members with: Advanced or metastatic stage 3 or 4 cancer, and cancer progression or recurrence in the MMC Member with advanced or metastatic stage 3 or 4 cancer. For additional information, providers can contact KP's Member Services Call Center at (855) 839-7613 for assistance.

Care Coordination

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

- **Behavioral Health**: KP provides timely access to Non-Specialty Mental Health Services (NSMHS) for MMC Members in outpatient mental health settings for adult and child MMC Members with mild to moderate levels of mental health impairment. MMC Members may be managed by Primary Care Physicians (PCP) within their scope of practice, or KP Behavioral Health, as appropriate. MMC Members are referred by KP Behavioral Health to the local County Mental Health Plan (MHP) for Specialty Mental Health Services (SMHS), including inpatient and outpatient services for MMC Members with severe mental health conditions, wraparound, and other Short-Doyle mental health services; and to the County MHP programs for substance use disorder treatment services. KP Behavioral Health assesses MMC Members' level of treatment need and refers to County MHP programs based on clinical necessity. KP ensures MMC Members access to medically necessary SMHS when County MHP services are delayed or not available. The referral process to County MHP services may vary by County. For additional information, contact KP's Behavioral Health Department for assistance at 1-833-579-4848 Monday through Friday, from 8:00 a.m. to 5:30 p.m. PST.

- **Substance Misuse Screening - Assessment, Brief Interventions and Referral to Treatment (SABIRT)**: PCPs are responsible for screening MMC Members ages 11 and older for tobacco, alcohol and drug use using validated screening tools. KP provides SABIRT services for MMC Members 11 years of age and older, including pregnant women. When, during the screening process, a MMC Member is identified as engaging in risky or unhealthy drinking or drug use, KP provides brief behavioral counseling interventions to reduce unhealthy substance use.

  These services may be provided by Providers within their scope of practice. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable Alcohol Use Disorder (AUD) or Substance Use Disorder (SUD). Brief interventions may be delivered by face-to-face sessions, written self-help materials, computer-or Web-based programs, or telephone counseling.

  KP ensures that MMC Members who, upon screening and assessment, meet the criteria for an AUD or SUD, or whose diagnosis is uncertain, are appropriately referred to the County department responsible for substance use treatment or KP Addiction Medicine services for Medication Assisted Treatment.

  KP makes a good faith effort to confirm whether MMC Members receive referred treatments and document when and where MMC Members receive treatment and any next steps following treatment for coordination of care. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Dyadic Services**: KP provides access to prevention and early intervention Behavioral Health services for KP MMC Members (children and youth, (ages 0-20)) and their parents/caregivers, integrated with pediatric well-child visits or adult primary care visits. Covered Dyadic Services are provided by a multi-disciplinary team including pediatrics, primary care, medical social work, and other specialty services. Dyadic Care is provided within pediatric primary care settings when possible. The Dyadic Behavioral Health (DBH) visit should occur on the same day as the well-child visit whenever feasible. When not possible, KP schedules the DBH visit as close as possible to the well-child visit. Treatment, referrals and coordinated linkage to services are also a covered Dyadic Services benefit. The Dyadic Services benefit also covers up to five (5) family therapy sessions without a diagnosis. Additional family therapy sessions are covered when the MMC Member or their parents/caregivers have risk factors for mental health disorders or related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/persistent bullying; and discrimination. For additional information, contact KP's Member Services Call Center at (855) 839-7613 for assistance.

- **Eating Disorders**: KP is responsible for coordinating care and providing medically necessary services for MMC Members who are diagnosed with eating disorders (EDO) and are currently receiving SMHS from a County MHP. For EDO services provided by Partial Hospitalization Programs (PHP) and Residential Treatment Centers (RTC), KP is responsible for the medically necessary physical health components and the MHP is responsible for the medically necessary SMH services components. KP is responsible for care coordination for step-up/down and transitions of care and following up to ensure

medically necessary services were rendered. In coordination with the County MHP, KP may assist with higher level of care placement, such as EDO Intensive Outpatient (IOP), Partial Hospitalization (PHP) or Residential Treatment Center (RTC). For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **No Wrong Door**: KP ensures that MMC Members receive timely mental health services without delay regardless of the delivery system where they seek care, and that MMC Members may maintain treatment relationships with trusted providers without interruption in certain situations. KP maintains robust care coordination responsibilities for all MMC Members, including those with Specialty Mental Health (SMH) needs that have been referred to and are receiving care with the County Mental Health Plan (MHP). KP coordinates MMC Members' SMHS and NSMHS. Continuity of care considerations apply. If a MMC Member needs SMH services and the Member experiences delayed access to medically necessary care with the MHP, KP coordinates with the MHP to ensure access to care. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services**: KP uses DHCS required Screening Tools (Youth and Adult) for MMC Members new to mental health services, and a Transition of Care tool (TOC) for MMC Members currently being seen by a KP network mental health provider. DHCS Screening and Transition of Care Tools are unique to the Medi-Cal program and are administered by Medi-Cal Health Plans (MCP) and County MHPs. The Adult Screening Tool for Medi-Cal Mental Health Services and Youth Screening Tool for Medi-Cal Mental Health Services determine where MMC Members who are new to Behavioral Health receive services, either through KP or the County MHP. The DHCS Screening Tools do not replace KP protocols and policies for Crisis, Emergency or Urgent Care. The Transition of Care Tool for Medi-Cal Mental Health Services is used when a MMC Member who is receiving KP mental health services experiences a change in their service needs and their services need to be transitioned to the County MHP or County services need to be added to their existing mental health treatment. This form includes relevant clinical information for coordinating care to and from the County MHP. When a MMC Member requires a transition of their mental health care to the County MHP, KP continues providing care until the Member is linked to clinically appropriate care with the County. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Behavioral Health Treatment (BHT) Services for Members Under the Age of 21**: All medically necessary Medi-Cal for Kids and Teens services (formerly EPSDT) including Behavioral Health Treatment (BHT) services, are covered for MMC Members under 21 years of age. Medical necessity decisions are individualized, and MMC Member's and the recommended BHT services must meet specific eligibility criteria. To meet the criteria for MMC Members under the age of 21:

    - MMC Members must receive a referral for BHT services from a licensed physician, surgeon, or psychologist that evidenced-based BHT services are medically necessary.

- The MMC Member must be medically stable and not in need of 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

Re-authorization for BHT services happens at least every six months with the submission of a person-centered and individualized behavioral health treatment plan developed, provided, and supervised in accordance with an MCP-approved behavioral treatment plan. The plan is developed reviewed, revised, and/or modified no less than once every six months by a BHT service Provider who meets the requirements in California's Medicaid State Plan: Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional.

The following BHT services are not covered under the Medi-Cal for Kids and Teens (formerly EPSDT) benefit:

- Services rendered when continued clinical benefit is not expected.
- Provision or coordination of respite, day care, recreational services, educational services, or reimbursement for a legal guardian's participation.
- Treatment where the sole purpose is vocationally or recreationally based.
- Custodial care, where BHT services aim to maintain safety and could be provided by persons without professional skills or training.
- Services, supplies, procedures performed in non-conventional settings - resorts, spas, camps; services rendered by a parent or legal custodian.
- Services that are not evidence-based behavioral intervention practices.

BHT services are not limited based on school attendance or other categorical exclusions, and treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. KP Care Delivery and Behavioral Health Teams partner with MMC Members, families, clinicians and services providers across settings, such as regional centers, local educational agencies, or LEAs, schools, and County Mental Health Plans (MHPs), to arrange, coordinate, address gaps, and maintain continuity for all medically necessary BHT services covered by Medi-Cal for MMC Members under the age of 21. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Blood Lead Screening**: In accordance with state and federal requirements, KP requires contracted PCPs to screen children enrolled in Medi-Cal for elevated Blood Lead Levels (BLL) as part of required prevention services offered through Medi-Cal for Kids & Teens (formerly EPSDT)

  In accordance with Medi-Cal for Kids & Teens, the contracted PCP must:

  - Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member of lead exposure risks.
  - Order or perform blood lead screening tests on all child members meeting eligibility criteria and follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

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

  Upon diagnostic evidence that a MMC Member under 21 years old may have a CCS eligible condition, KP must ensure the MMC Member's information is sent to the local CCS office for an eligibility determination. CCS eligibility is determined by the county CCS agency where the MMC Member lives.

  KP is responsible for all medically necessary covered services that are unrelated to the county approved CCS eligible condition. KP is responsible for the coordination of services and joint case management between Plan providers, CCS specialty providers, and the local county CCS program. If the local county CCS program does not approve eligibility for any reason, KP remains responsible for all medically necessary covered services.

  KP does not cover services provided by the CCS program except for MMC Members enrolled in Whole Child Model (WCM) counties. The WCM program incorporates CCS covered services for CCS eligible MMC Members. Under WCM, KP covers CCS eligible conditions for MMC Member residing the following county: Orange County.

- **Children with Special Health Care Needs**: Children with Special Health Care Needs (CSHCN) are defined as "children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally." A CSHCN identified MMC Member receives a comprehensive assessment of health and related needs, including needed referrals for additional supports and services as applicable. Please direct any MMC Member requests for the above listed services, to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Coordination with Local Education Agency Services**: KP collaborates with Local Education Agencies (LEAs) in the development of Individual Education Plans (IEPs) or Individual Family Service Plans for its MMC Members. Please direct any MMC Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Developmental Disabilities**: KP refers MMC Members with developmental disabilities to a Regional Center for evaluation. Children with a developmental disability are eligible for or being served by Regional Centers. Eligibility is established through diagnosis and assessment performed by regional centers. The following must be met to be determined eligible:

  - Intellectual Disability
  - Autism
  - Epilepsy
  - Cerebral Palsy

- Condition that closely resembles intellectual disability and/or results in the individual requiring similar services
- The disability originates prior to age 18, is expected to be lifelong and constitutes a substantial disability for the individual. "Substantial disability" means significant functional limitations in three or more of the following areas:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency

Please direct any MMC Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Early Intervention Services/Early Start Program**: KP identifies children who may be eligible for a referral to a local Early Start program to address developmental delays. KP covers/provides all medically necessary speech, occupational, and physical therapy services for MMC Members with a developmental delay regardless of age. Early Start is early intervention services in California for families with infants and toddlers who have developmental delays or disabilities. Any child under 3 years of age may be eligible if they:

  - Have a developmental delay of at least 25% in one or more of the following: Cognitive (thinking and learning); expressive communication (talking and expressing self); receptive communication (understanding language); social and emotional (feeling, expressing, interacting); adaptive (everyday living skills like eating, dressing, caring for self); and physical and motor development, including vision and hearing (walking, moving, seeing, and hearing).
  - Have an established risk condition of known cause, with a high likelihood of delayed development.
  - Are likely to have a developmental delay due to a number of risks that have been confirmed by a professional.

  Please direct any MMC Member requests for the above listed services to their PCP. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **HIV/AIDS**: KP must ensure that members have access to HIV testing and counseling services, including access through a Local Health department (LHD). KP must not require prior authorization or referral for members to access HIV testing services. KP is responsible for the identification and referral of MMC Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program. For more information on Medi-Cal waiver programs please visit: https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx

- **Dental**: While dental services are carved-out services and covered through DHCS Medi-Cal Dental Program, KP must cover and ensure that dental screenings and oral health

assessments are included for all MMC Members. For MMC Members under 21 years of age, dental screenings/oral health assessments are performed as part of every periodic assessment. KP provides referrals to Medi-Cal Dental Providers for all MMC Members and on an annual basis for MMC Members under 21 beginning with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. KP provides dental screenings during the Initial Health Appointment (IHA). KP provides other dental services that can be provided by a Medical Provider including medically necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. KP does not cover dental services exclusively provided by a Dental Provider or Dental Anesthetist. KP also covers services related to dental procedures that require IV moderate sedation and deep sedation/anesthesia when provided by individuals other than a dental provider.

- **Women, Infants, and Children Supplemental Nutrition Program**: The Women, Infants, and Children Supplemental Nutrition Program (WIC) is a nutrition/food program that helps pregnant, breastfeeding, or postpartum MMC Members, and MMC Members less than five (5) years of age to eat well and stay healthy. KP is responsible for the identification, referral, and documentation of the referral of MMC Members in need of WIC services who fall in the category of pregnant, breastfeeding, post-partum, or a legal guardian for a MMC Member under the age of five. If need is identified during the evaluation of a pregnant, breastfeeding, postpartum MMC Member, or child under the age of five, KP will provide a referral to WIC with all required clinical elements and signatures to process the referral. The MMC Member will need the completed WIC referral form to take with them to the WIC agency or it may be transmitted directly to the agency. For additional information, contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Major Organ Transplant Services**: Major Organ Transplants (MOT) are the responsibility of Medi-Cal MCP for all adult MMC Members (21+ years of age), all pediatric MMC Members (under 21) participating in the Whole Child Model program, and all pediatric Members not eligible for CCS enrolled in a plan. Eligible pediatric MMC Members must be referred to DHCS-approved transplant Special Care Center (SCC) and will require a CCS Service Authorization Request (SAR). KP must directly refer adult MMC Members and MMC Members less than 21 years of age participating in the WCM program or authorize referrals to a transplant program that meets DHCS criteria for an evaluation, within 72 hours of a MMC Member's PCP or specialist identifying the MMC Member as a potential candidate for MOT and receiving all of the necessary information to make a referral or authorization. KP can then authorize the request for the MOT after the transplant program confirms the MOT candidacy of the MMC Member. KP must refer non-WCM MMC Member less than 21 years of age to the county CCS Program for eligibility determination within 72 hours of the MMC Member's PCP or specialist identifying the MMC Member as potential candidate for transplantation. KP is required to cover transplant and transplant-related services for its MMC Members who are enrolled with KP for Medi-Cal services. KP contracts with DHCS approved Centers of Excellence (COEs) for its transplant network. A COE is a transplant center that has received DHCS designation to confirm that the transplant unit within the hospital meets DHCS criteria for a transplant program. Providers or their clinic staff should contact the Transplant HUB at 1-888-551-2740 for additional details or care coordination needs.

- **Non-Duplication of Services**: Providers must coordinate with the MMC Member and KP to ensure that the services they are receiving are appropriate and non-duplicative.

These services may be delivered from external entities outside of KP such as local government agencies, local health departments, County mental health programs, and community-based partners. These services may also be provided internally through KP. If a MMC Member is enrolled in another care/case management program or may be receiving duplicative services through another program, Providers should notify KP's Member Services Call Center at (855) 839-7613 for assistance.

Chiropractic Benefits

For Adult MMC Members ages 21 and older with an allowable diagnosis, KP covers chiropractic services, limited to the treatment of the spine by manual manipulation. All other services provided by a chiropractor are excluded from coverage.

Chiropractic services from American Specialty Health network providers. We work with American Specialty Health to arrange chiropractic services for the following MMC Members:

- Children under age 21, and after they turn age 21 that require treatment of an acute episode
- Pregnant MMC Members through 365 days postpartum
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility
- Enrollees in the Program of All-Inclusive Care for the Elderly (PACE), if applicable

For more information on chiropractic services, eligible MMC Members please call American Specialty Health at 1-800-678-9133 (TTY 711).

- **Chiropractic services from County Facilities, Federally Qualified Health Centers, and Rural Health Centers**: Medi-Cal may cover chiropractic services for MMC Members of all ages with an allowable diagnosis when received at county hospital outpatient departments, county outpatient clinics, FQHCs, or RHCs that are in Kaiser Permanente's network. FQHCs and RHCs may require a referral to get services. Not all county facilities, FQHCs or RHCs offer outpatient chiropractic services. To get more information, call Member Services at 1-855-839-7613 (TTY 711).

Claims and Encounter Data Submission

Periodic reporting of encounter data is a requirement for MCP Providers. Contracted providers must ensure the complete, accurate, reasonable, and timely submission of claims and encounter data to KP. KP encourages the electronic submission of claims and encounter data. If you have questions about electronic submission, please contact the Southern California KP EDI Helpline at 1-866-285-0361, or visit KP's Community Portal, Claims at: https://healthy.kaiserpermanente.org/southern-california/community-providers/claims.

Clinical Practice Guidelines

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

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

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

The KP CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the KP Guidelines Medical Director. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are available by contacting KP Member Services Call Center (MSCC) at 1-855-839-7613 or contacting the KP referring physician.

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

Continuity of Care (COC)

The law requires KP to inform our Providers about the Continuity of Care (COC) provisions within the law. MMC Members new to KP may be eligible to receive COC from their prior Out-of-Network (OON) Provider. The MMC Member may request COC for up to 12 months after the enrollment date with KP, if a pre-existing relationship exists with that OON Provider, regardless of the MMC Member having a condition listed in HSC section 1373.96. Continuity of Care protections extend to PCP, Specialists, and select ancillary Providers, including physical therapy, occupational therapy, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy providers. A pre-existing relationship means the MMC Member has seen the OON Provider for a nonemergency.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts which are payable when a member is covered under more than one health benefit plan. It is intended to prevent duplication of benefits when an individual is covered by multiple health benefit plans providing benefits or services for medical or other care and treatment. Medi-Cal is always the payer of last resort. Please visit KP's Community Portal, Coordination of Benefits and Medi-Cal Cost Avoidance at: https://healthy.kaiserpermanente.org/southern-california/community-providers/medi-cal. For questions contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Data Exchange

KP and its Subcontractors and Network Providers are obligated to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.

Diversity, Equity, and Inclusion (DEI) Training

KP promotes access to and delivery of services in a culturally competent manner to all MMC Members and potential MMC Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.53.

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

DHCS requires that KP's DEI training program be region specific and at minimum include consideration of health-related social needs that are specific to KP's servicing counties, regional demographics, and disparity impacts of all of KP's current MMC Members, including but not limited to:

- Seniors and Persons with Disabilities (SPDs)
- MMC Members with chronic conditions
- MMC Members with Specialty Mental Health Services (SMHS) and/or Substance Use Disorder (SUD) needs
- MMC Members with intellectual and Developmental Disabilities (DD)
- Children with Special Health Care Needs (CSHCN)

KP must ensure that its contracted Network Provider complete DEI training at least once every two years. This training helps reinforce KP's commitment to the effective delivery of health care services in a culturally competent, sensitive, and inclusive manner that meets the social, cultural, and linguistic needs of our MMC Members.

DEI training materials are available on the KP Community Provider Portal at: https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

Durable Medical Equipment (DME) Coverage

Medi-Cal coverage for Durable Medical Equipment (DME) may cover some items not usually covered by other insurance or Medicare. Examples include incontinence supplies, shower chairs, and some types of wheelchairs. Prior Authorization is required for DME. For further information on ordering DME, please contact the MMC Member Services Call Center at 1-855-839-7613. For MMC Members with Dual coverage, their primary coverage may cover above items; Medi-Cal is secondary coverage. For assistance with Medi-Cal DME benefits, please contact KP's Member Service Contact Center.

Electronic Visit Verification (EVV)

EVV is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. The program aids in reducing fraud, waste, and abuse. All Medi-Cal Personal Care Services (PCS) and Home Health Care Services (HHCS) Providers must capture and transmit the following six mandatory data components:

1) The type of service performed.
2) The individual receiving the service.
3) The date of the service.
4) The location of service delivery.
5) The individual providing the service; and
6) The time the service begins and ends.

KP will monitor our Providers to ensure compliance with these requirements in accordance with the established guidelines per EVV requirements.

- Monitor Providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues.
- Supply Providers with technical assistance and training on EVV compliance.
- Require Providers to comply with an approved corrective action plan.
- May deny payment if the Provider is not complying with EVV requirements and might arrange for the MMC Members to receive services from a Provider who does comply.

When a Provider is identified as non-compliant with these requirements, KP may not authorize the Provider to perform services and/or withhold the payment. If a non-compliant Provider is the employee of a subcontractor, the specific Provider will not be able to provide Medi-Cal PCS and HHCS services.

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.

Facility Site Review

All PCP sites participating in the Medi-Cal Managed Care Program and the Medicare-Medicaid Plans are required by California Code of Regulations (22 CCR § 56230) and California Department of Health Care Services (DHCS) to complete Facility Site Reviews:

- **Initial site review**: Consists of an initial Facility Site Review (FSR) and an initial Medical Record Review (MRR) before joining KP's provider network. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. The MRR is conducted within 90 -180 days of MMC Member assignment. Each site must also have a Physical Accessibility Review Survey (PARS) to assess the physical adequacy of provider sites that provide services to

Seniors and Persons with Disabilities (SPDs). PARS are also required of high-volume specialty and ancillary providers, and Community Based Adult Services (CBAS).

- **Subsequent site review**: Conducted every three years at minimum, consisting of FSR, MRR and the Physical Accessibility Review Survey (PARS).

- **Ongoing Monitoring**: Occurs between regularly scheduled 3-year site review audits. Monitoring methods may include site reviews, information gathered for quality improvement, as well as Provider and program-specific reports from external sources (e.g., public health). At a minimum, an evaluation of all Critical Elements (CEs).

At Kaiser Permanente, DHCS-Certified Nurse Reviewers conduct the FSR and MMR and score them with standardized DHCS guidelines and audit tools. Corrective Action Plans are required for those providers who do not meet the minimum required score.

Fraud, Waste, and Abuse

Providers and their staff must be trained on Fraud, Waste, and Abuse, to comply with requirements of California's Medi-Cal regulator, DHCS.to report a concern related to fraud, waste, or abuse, call the Compliance Hotline at 1-888-774-9100.

Health Education

KP is required to maintain a robust health education system for MMC Members, including educational workshops, telephonic wellness coaching, consultation, support groups, and print as well as online health information. Through this system, MMC Members are provided information, tools, and resources to improve health, support behavior change/lifestyle management, and better manage disease. MMC Members may access health education services in-person at a local Health Education department, on kp.org or via phone. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Home and Community Based Services Waivers

1915(c) HCBS Waiver Programs Home and Community-Based Services (HCBS) Waiver Programs provide services aimed at serving individuals who would otherwise qualify for institutional care in community-based settings. These MMC Members are enrolled in KP, and KP is responsible for identifying, referring, and coordinating services for MMC Members enrolled in HCBS. HCBS waiver services are provided directly by DHCS. In California, there are several waiver programs eligible Members can enroll in to receive these services, including but not limited to:

- Assisted Living Waiver: Care for MMC Members in residential care as an alternative to a SNF. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx
- Home and Community Based Alternatives Waive provides care management and services to support MMC Member's living in a community-based arrangement. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

- Multipurpose Senior Services Program Waiver provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. Link here: https://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx
- Medi-Cal Waiver Program (MCWP, formerly AIDS Waiver Program) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/AIDS.aspx
- HCBS Waiver for the Developmentally Disabled (HCBSDD) and Self Determination Program (SDP) Waiver administered by the California Department of Developmental Services (DDS), HCBS-DD provides services for developmentally disabled persons who are Regional Center consumers. Link here: https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

MMC Members can be enrolled in a 1915(c)-waiver program or ECM, but because both offer comprehensive care management, a MMC Member cannot enroll in both at the same time.

Initial Health Appointment (IHA)

The Initial Health Appointment (IHA) is a Medi-Cal managed care requirement for adults and children to ensure new MMC Members receive a comprehensive assessment by a PCP. The IHA is required to be completed within 120 days of Medi-Cal Managed Care Plan enrollment for new MMC Members and must include a history of the MMC Member's physical and be documented in the MMC Member's medical record. Preventative screenings for adults and children as recommended by the United States Preventative Services Taskforce (USPSTF) do not need to be completed during the IHA, so long as MMC Members receive all required screenings consistent with USPSTF guidelines.

The components of the IHA include history of the MMC Member's physical and mental health, identifications of risks, assessment of need for preventative screen or services, health education, and the diagnosis and plan for treatment. The IHA must be completed for all MMC Members, be performed by a Provider within the primary care setting and provided in a way that is culturally and linguistically appropriate for the MMC Member. Exceptions to the IHA are if the MMC Member's PCP determines that the medical record contains complete information that was updated within the past 12-months, the MMC Member was not continuously enrolled in the plan and/or disenrolled within 120 days, a MMC Member refuses IHA completion or the MMC Member missed a scheduled appointment, and there are documented attempts to reschedule the appointment.

Interoperability and Patient Access

"Interoperability" refers to an application programming interface (API) technology that allows one software application to programmatically access the services provided by another software application.

KP maintains a secure Patient Access API and a Provider Directory API that connects to mobile applications, Provider electronic health records, and the practice management system. Both the Patient Access API and the Provider Directory API are available to Members. Members have the right to share their information with a third-party web or mobile application of their choice.

Language Assistance/Interpreter Services

High quality and timely language assistance that is free of charge and available 24 hours/day, 7 days/week or during all hours of business must be provided to all KP MMC Members. For further information, please refer to the Additional Information: KP's Language Assistance Program section of the Provider Manual for HMO Members available at: https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

Managed Long Term Services and Supports (MLTSS)

MLTSS encompasses several services, including Community-Based Adult Services (CBAS), Long Term Care (LTC), Multi-purpose Senior Support Programs (MSSP), and In-Home Supportive Services (IHSS). Eligibility for these programs often requires an assessment and pre-authorization.

If you identify a KP Medi Cal member who may be eligible for any of these MLTSS services, please contact the Regional Complex Case Management Department at 1-866-551-9619 (TTY users call 711) for assistance. Department staff are available Monday through Friday from 8 a.m. to 5:30 p.m.

- **Community-Based Adult Service**: The Community Based Adult Services program (CBAS) is intended to help MMC Members maintain the highest possible level of functioning in a community environment as opposed to placement in a nursing facility. This facility-based service provides Adult Day Health Care services to MMC Members who meet medical necessity criteria for LTC services. MMC Members may attend one to five days per week, and transportation to and from home is provided. For assistance contact KP's Regional Complex Care Management Department at 1-866-551-9619 (TTY users call 711).

- **Long Term Care**: For MMC Members, institutional Long-Term Care (LTC) includes admission to Skilled Nursing Facilities (SNF) (both freestanding and hospital-based SNFs), Adult subacute facilities, Pediatric subacute facilities, and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). MMC Members must meet medical necessity criteria for LTC services.

- **Multi-purpose Senior Support Programs**: Multipurpose Senior Services Program (MSSP) waiver provides Home and Community-Based Services (HCBS) for MMC Members who are 65 years or older and disabled, as an alternative to nursing facility placement. Examples include respite care, additional personal care services, and meals. Coordination for MSSP is by the Managed Care Plan, payment is by the County. The MMC Member must meet eligibility requirements: meet Nursing Facility level of care, aged 65 years and older, shall only be enrolled in one HCBS waiver at any time, must reside in a County with an MSSP site. PCPs may advise MMC Members in need of MSSP to contact their local MSSP office for assistance or KP's Regional Complex Care Management Department at 1-866-551-9619 (TTY users call 711).

- **In Home Support Services**: In Home Support Services (IHSS) are for MMC Members who need assistance with Activities of Daily Living (ADL) or Instrumental Activities of

Daily Living (IADL) to live safely in their homes. Examples of IHSS include meal prep and clean up, laundry services, bathing and grooming assistance, grocery shopping, running errands, escort to medical appointments, household and yard cleaning, and protective supervision. Coordination for IHSS is by the MCP; payment is by the County. PCPs may advise MMC Members in need of IHSS to contact their local IHSS office for assistance, or KP's Regional Complex Care Management Department at 1-866-551-9619 (TTY users call 711).

Mandatory Managed Care Enrollment (MMCE)

Dually eligible Medicare and Medi-Cal beneficiaries and institutional long-term care populations will transition from fee for service Medi-Cal to mandatory managed care enrollment effective January 1, 2024. There are some exemptions to mandatory managed care enrollment that could impact a small number of Members.

If there is a need to verify benefits and eligibility, please refer to the Online Affiliate tool by visiting the KP Community Provider Portal at: https://healthy.kaiserpermanente.org/southern-california/community-providers/online-provider-tools. Select Online Provider Tools to view Eligibility.

Medi-Cal for Kids & Teens (formerly Early Periodic Screening, Diagnosis, and Treatment Programs (EPSDT))

Under the Medi-Cal for Kids and Teens Program, KP provides and covers all medically necessary services, defined as any service that meets the standards set forth in Title 42 of the USC section 1396(r)(5), unless otherwise carved out of the KP contract with DHCS, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

Medi-Cal for Kids & Teens services include comprehensive screening including Blood Lead Screening, vision, dental, and hearing services at intervals that meet reasonable standards of medical/dental practice and as medically necessary as well as other necessary health care, behavioral health, diagnostic services, treatment, and services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services for individuals under the age of 21 who are enrolled in Medi-Cal. Starting January 1, 2024, KP is required to ensure all Network Providers complete a DHCS supplied Medi-Cal for Kids & Teens specific training no less than every two (2) years. Please see KP's Community Provider Portal, Managed Medi-Cal Program section, for training requirements at https://healthy.kaiserpermanente.org/southern-california/community-providers/provider-info

Please direct any MMC Member requests for the above listed services to their PCP. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

Member/Provider Complaints, Grievances & Appeals

A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care

or services provided, any aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the health plan to make an authorization decision. An initial determination is a type of grievance which also includes a request for referral, provision of or reimbursement for services or supplies, or other financial resolution, regardless of how that dissatisfaction is submitted to KFHP.

MMC Members, or an authorized representative acting on behalf of an MMC Member, may submit a Grievance or an Initial Determination in person, by phone 1-855-839-7613, by email or online through the KP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (Attn: Kaiser Permanente Civil Rights Coordinator, Member Relations Grievance Operations, PO Box 939001, San Diego, CA 92193) for investigation and resolution. KP does not limit the timeframe during which the MMC Member is eligible to submit a grievance or an initial determination. Standard grievances are processed within 30 calendar days. Initial determinations are processed within 14 to 30 calendar days, depending on the type of request. Expedited grievances and initial determinations are processed within 72 hours. The MMC Member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases. A notice of resolution is provided, in the MMC Member's preferred language, to the MMC Member within 30 calendar days from the date the MMC Member makes an oral or written standard Grievance or Appeal, or 72 hours for an expedited Grievance or Appeal.

An appeal is defined as a review of an initial adverse decision/Notice of Action. MMC Members, or an authorized representative acting on behalf of a MMC Member, may submit an appeal in person, by phone 1-855-839-7613, by email or online through KFHP website (kp.org), by facsimile 1-855-414-2317, or in writing to KP (Member Case Resolution Center, PO Box 939001, San Diego, CA 92193, for standard appeals; Expedited Review Unit, PO Box 1809, Pleasanton, CA 94566, for urgent/emergent appeals), for investigation and resolution. KFHP allows 60 calendar days from the date of the adverse benefit determination or the NOA for the MMC Member to file an appeal. If the MMC Member wants to continue care which the adverse benefit determination or the NOA is terminating, suspending, or reducing, KFHP allows 10 calendar days from the postmarked date of the adverse benefit determination or NOA, and before the intended effective date of the adverse benefit determination being disputed, for the MMC Member to file an appeal. Standard appeals are processed within 30 calendar days. Expedited appeals are processed within 72 hours. The MMC Member will be notified of the applicable timeframe within 5 calendar days for standard cases or 24 hours for expedited cases.

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

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

MMC Members, or an authorized representative acting on behalf of an MMC Member, have 120 days to ask for a state hearing from the date the MMC Member became unhappy. One can ask for a state hearing at any time during this 120-day period, including before, during, or after the MMC Member files a grievance. Once the judge decides the case, the MMC Member cannot

ask for binding arbitration. If the MMC Member asks for a state hearing, the MMC Member may not be able to get an independent medical review later.

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

California Department of Social Services
Expedited Hearings Unit State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

Member Rights and Responsibilities

MMC Members have the following rights, guaranteed to them by DHCS:

- To be treated with respect, giving due consideration to the MMC Member's right to privacy and the need to maintain confidentiality of the MMC Member's Protected Health Information (PHI) and Private Information (PI).
- To be provided with information about KP and all services available to MMC Members.
- To be able to choose their Primary Care Provider (PCP) within KP's Network unless the PCP is unavailable or is not accepting new patients.
- To participate in decision-making regarding their health care, including the right to refuse treatment.
- To submit Grievances, either verbally or in writing, about KP, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
- To request a State Fair Hearing, including information on the circumstances under which an expedited State Fair Hearing is available.
- To receive interpretation services and written translation of critical informing materials in their preferred threshold language, including oral interpretation and American Sign Language.
- To have a valid Advance Directive in place, and an explanation to MMC Members of what an Advance Directive is.
- To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of KP's Network.
- To have Emergency Services provided in or outside of KP's Network, as required pursuant to federal law.
- To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Service (IHS) Programs outside of KP's Network, pursuant to federal law.

- To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 CFR sections 164.524 and 164.526.
- To change Medi-Cal managed care plans upon request, if applicable.
- To access Minor Consent Services.
- To receive written MMC Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 45 CFR sections 84.52(d), 92.102, and 438.10.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate for the MMC Member's condition and ability to understand available treatment options and alternatives.
- To freely exercise these MMC Member rights without retaliation or any adverse conduct by KP, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

If a MMC Member expresses dissatisfaction with the treatment plan and/or with a Provider's response to the Member's request for a service/item, and the Provider is unable to resolve the issue, it is appropriate to remind the MMC Member of their right to file a grievance and can contact KP's Member Services Call Center at 1-855-839-7613 for assistance. Requirements and timeline for filing a Grievances and Appeals are listed in the Medi-Cal Member handbook, please visit: https://healthy.kaiserpermanente.org/southern-california/shop-plans/medicaid/new-members

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

Minor Consent Services

Under California law, MMC Members under the age of 18 can see a doctor without consent from their parents or guardian for the following types of care. Medical records and/or information regarding medical treatment specific to these services must not be released to the parent(s) or guardian(s) without the minor's consent. These services include:

- Sexual assault, including rape;
- Drug and alcohol abuse for children 12 years of age or older;
- Pregnancy services, including abortion;
- Family planning services (except sterilization);
- Sexually transmitted disease and HIV/AIDS diagnosis and treatment in children 12 years of age or older;
- Outpatient mental health for children 12 years of age or older who are mature enough to participate intelligently and where either (a) there is danger of serious physical or mental harm to the minor or others, or (b) the child is the alleged victim of incest or child abuse, sexual or physical abuse.

Overpayments

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

Pharmaceutical Management

Outpatient Pharmacy services are carved out to Medi-Cal Rx which covers prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim. KP must inform and provide MMC Members linkage to Medi-Cal Rx Pharmacy services, including available alternative primary Pharmacy.

MMC Members may access covered medications at any Medi-Cal FFS pharmacy Provider. KP is no longer managing the formulary applicable to MMC Members. The DHCS Drug Formulary, now called the Contract Drug List, can be accessed using the following link: https://medi-calrx.dhcs.ca.gov/home/cdl/

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

Additional information related to drug coverage can be found by visiting: https://medi-calrx.dhcs.ca.gov/home/. Clinic-administered drugs that are provided to patients during inpatient stays, clinic encounters, home health visits, or as part of long-term care will still be covered by KP. KP will also ensure the provision of at least a 72-hour supply of a medically necessary, covered outpatient drug when the drug is prescribed in an emergency.

Grievances related to Medi-Cal Rx prescriptions should be submitted to Magellan's Medi-Cal Rx Customer Service Center (CS). MMC Members can submit a complaint either in writing or by telephone by going to https://medi-calrx.dhcs.ca.gov/home/ or calling Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week.

For clinic-administered drugs or prescription items covered by KP under state law, MMC Members will continue to submit grievances to KP. Please see Member/Provider Complaints, Grievances & Appeals section above for more information on how to submit a grievance to KP.

Population Health Management (PHM)

KP has a PHM program that ensures all MMC Members have equitable access to necessary wellness and prevention services, care coordination, and care management. PHM is a model of care that addresses individuals' health needs at all points in the continuum of care, including the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychological well-being

of individuals and address health disparities through cost-effective and tailored health solutions. These services include, but are not limited to:

- **Member Risk Stratification**: The PHM program involves assessing and stratifying the population of MMC Members to ensure they are connected to the appropriate services for their needs.

- **Basic Population Health Management (BPHM)**: BPHM is an approach to care that ensures needed programs and services are made to each MMC Member at the right time and in the right setting. This includes access to Primary Care Services, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers, wellness and prevention programs, chronic disease programs, programs focused on improving mental health outcomes, and case management services for children under Medi-Cal for Kids and Teens (formerly EPSDT).

  All KP MMC Members have access to a variety of evidence-based comprehensive wellness programs that meet National Committee for Quality Assurance (NCQA) PHM standards including, but not limited to, managing stress, identifying depressive symptoms, access to preventive health visits, screenings, etc.

  KP has Disease Management programs available to help empower individuals with chronic conditions to better understand and manage their disease. Disease management consists of population/care management programs for MMC Members with asthma, diabetes, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF) and chronic pain.

  Please direct any Member requests for the above listed services to their PCP. For additional information, Providers can contact KP's Member Services Call Center at 1-855-839-7613 for assistance.

- **Complex Care Management (CCM)**: Complex Care Management is a service for MMC Members with complex needs who need extra support to avoid adverse outcomes. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting at the right time. CCM is intended for higher- and medium-rising-risk MMC Members with a medically complex condition or MMC Members with a medical condition and a complex social situation that impacts the medical management of the MMC Member's care. For additional information, Providers can contact 1-866-551-9619.

- **Enhanced Care Management (ECM)**: KP provides access to enhanced care management, which is person-centered care management provided to MMC Members who meet criteria for one of DHCS' ECM Populations of Focus. The benefit is provided primarily through in-person engagement where enrollees live, seek care, and choose to access services. To place a referral or for additional information, Providers can contact 1-866-551-9619.

- **Community Supports**: KP contracts with community-based organizations to offer Community Supports, such as housing supports for people experiencing homelessness,

medically tailored meals, and supports in the home, which will play a fundamental role in meeting MMC Members' needs for health and health-related services that address social drivers of health. To place a referral or for additional information, Providers can contact Providers can contact 1-866-551-9619.

- **Community Health Worker Services (CHW)**: Community Health Worker Services are defined as preventive health services delivered by a non-licensed CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs must have shared lived experiences with KP MMC Members and ties to the communities they serve. CHWs may assist MMC Members in achieving specific care goals related to health education, health navigation, screening and assessments performed by a non-licensed individual, and individual advocacy. CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. For additional information, Providers can contact 1-866-551-9619.

- **Transitional Care Services (TCS)**: Per DHCS, care transitions are defined as a MMC Member transferring from one setting or level of care to another. While MMC Members are in non-KP facilities, Providers must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements. In addition, Providers are expected to coordinate with KP, to ensure that all TCS requirements outlined in the most recent version of the DHCS Population Health Management (PHM) Policy Guide are complete.

  The requirements include but are not limited to a) notifying KP, preferably by Admission, Discharge and Transfer (ADT), of a MMC Member's admission and discharge to a non-KP facility; b) including the name and phone number of a KP-assigned Care Manager in the discharge packet. KP will provide the Care Manager's information as a single point of contact to assist MMC Members throughout their transition and to ensure all required services are complete; c) sharing the discharge packet with the MMC Member, MMC Member's parents/guardians or authorized representatives, and KP to facilitate communication and Continuity of Care; and d) evaluate MMC Members on high-risk criteria, including Enhanced Care Management (ECM), NCQA Complex Case Management, Community Supports, and make referrals as appropriate.

  Providers should be familiar with the CalAIM TCS expectations and requirements for each population (e.g., complex care management) and establish policies and procedures to support care transitions in compliance with CalAIM TCS regulations. The most recent version of the PHM Policy Guide can be found at the DHCS website https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf

- **Population Needs Assessment (PNA) and Population Health Management Strategy**: KP will identify priority MMC Member health needs and health disparities in the communities it serves through KP's participation in the Population Needs Assessment (PNA). KP will meaningfully collaborate with local health departments (LHDs) on Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs) starting in 2024. KP continues to be accountable for meeting cultural, linguistic and health education needs of MMC Members, as defined in state and federal regulations. KP expects all Network Providers, Fully Delegated Subcontractors, and

Downstream Fully Delegated Subcontractors to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance (e.g., APLs, Policy Letters, PHM Policy Guide, and the DHCS Comprehensive Quality Strategy), including all relevant requirements regarding health education and cultural and linguistic needs.

The PHM Strategy is submitted annually and requires that KP demonstrates that it is meaningfully responding to community needs as well as providing other updates on the PHM Program to inform DHCS's monitoring efforts. KP will regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the PNA/PHM Strategy.

Post-Stabilization Care

In accordance with Title 28 CCR section 1300.71.4, when a MMC Member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services and may not be discharged safely, KP "shall approve or disapprove a health care Provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request." To clarify, the "health care Provider" as referenced herein refers to both Out-of-Network Providers (i.e., noncontracting Providers) and Network Providers, as well as all applicable Subcontractor and Downstream Subcontractor Agreements. Please contact KP Emergency Prospective Review Program (EPRP) at 1-800-447-3777 available 7 days a week/24 hours a day for assistance.

Primary Care Physician (PCP) Assignment

New MMC Members are assigned a PCP within 40 days of MMC Member enrollment and are notified via postal letter. New MMC Members who choose their personal physician have their choice confirmed at the time of their selection (on the phone or online). PCPs may refer MMC Members to specialists, when medically necessary. Contracted PCPs should work within established KP protocols to coordinate specialty care.

Examples of Specialists that require a referral include:

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

Provider Directory

KP must include the following information in our Provider directory for all contracted Providers:

- City/Region Header
- Providers or site name
- PCP number (if applicable)
- NPI number
- Primary Care Clinic or Medical Group/Independent Practice Association
- Provider address

- Telephone number
- Hours and days of operation
- How to use Plan services must be included
- Acronyms and symbols used must be included
- SPD Accessibility symbols and legend
- How/who to call for assistance
- Website URL for each location (if applicable)
- The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility, and if the Provider has completed cultural competence training
- Provider Hospital(s) (Optional)
- Instructions advising the MMC Member to contact member services to verify the availability of selected providers. Disclaimer should be on every page and instructions
- Closed Panel should only be used for providers not accepting new patients definitively.

Provider Enrollment

Federal and state requirements mandate that KP's Managed Care Plan (MCP) Network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program to render services to KP MMC Members. Most Network Providers enroll in Medi-Cal through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway. Alternately, some Medi-Cal MCPs maintain Medi-Cal enrollment units to enroll Network Providers solely for the purpose of participating in the Medi-Cal MCP's network. Network Providers enrolled through a MCP's enrollment unit are recognized by other MCPs as enrolled for the purpose of participation in the Medi-Cal program. Per federal regulation, Network Providers enrolled solely for the purpose of participation in a MCP's network are not required to render services to Medi-Cal Fee-For Service Members. KP does not maintain a Medi-Cal Plan enrollment unit. For more information about the DHCS Medi-Cal enrollment process, please visit the state's PED site:
https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Provider Grievances

Providers may file a grievance for any issue. Grievances must be submitted orally or in writing within 180 days of the incident resulting in dissatisfaction. For assistance, please contact KP's Member Service Contact Center at 1-855-839-7613.

Provider Medi-Cal Training

DHCS requires that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure full compliance with KP's contract with DHCS and all applicable federal and State statutes, regulations, All Plan Letters, and Policy Letters. Training must be started within 10 working days and completed withing 30 working days after KP places the newly contracted provider on active status. KP must also ensure ongoing training of Network Providers at least every 2 years. Newly contracted providers may access the Medi-Cal Managed Care Training in the Medi-Cal Section of KP's Community Provider Portal:
https://healthy.kaiserpermanente.org/southern-california/community-providers/medi-cal

If you have any questions about the provider training on Medi-Cal, please contact the Medi-Cal Program team at Medicaid-PROV-Team@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 MMC Member by that Provider. DHCS requires KFHP to report PPCs that are associated with claims for Medi-Cal payment (FFS or by a Managed Medical Plan) or for courses of PPC treatment prescribed to a MMC Member for which payment would otherwise be available. PPCs that existed prior to the initiation of treatment of the Member by the Provider are not reportable. After discovery of a PPC and confirmation that the patient is a Medi-Cal beneficiary, KP must report the PPC to the DHCS using the following website: https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx

Provider Suspension, Termination, or Decertification

KP must ensure timely compliance with all requirements associated with DHCS notification of a Provider's suspension, termination, or decertification from participation in the Medi-Cal programs. KP may terminate its contract with a Network Provider/Subcontractor and/or suspend payments to a Network Provider/Subcontractor in accordance with DHCS requirements.

For all terminations, KP must mail appropriate MMC Member notifications and remain accountable for all functions and responsibilities of the terminated Network Provider/ Subcontractor to ensure that impacted MMC Members do not experience disruption in access to care. If a contract is successfully renegotiated with a Network Provider/Subcontractor before the effective date of the contract termination, and MMC Member notices were already mailed out, KP must mail another notice to inform MMC Members that the contract is not being terminated.

Punitive Action Prohibitions

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

- For the MMC Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- For any information the MMC Member needs to decide among all relevant treatment options
- For the risks, benefits, and consequences of treatment or non-treatment
- For the MMC 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.

Sensitive Services

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

- Mental or behavioral health;
- Sexual and reproductive health;

- Sexually transmitted infections;
- Substance use disorder;
- Gender affirming care; and
- Intimate partner violence.

Sterilization

California law requires that MMC Members requesting sterilization services meet the following criteria:

- Be at least 21 years of age at the time consent is obtained;
- Not be mentally incompetent;
- Be able to understand the content and nature of the informed consent process;
- Not be institutionalized;
- Have voluntarily given their written informed consent using the PM 330 form noted below;
- At least 30 days, but not more than 180 days, have passed between the date of written informed consent and the date of sterilization, subject to very limited exceptions.

As indicated above, MMC Members requesting sterilization services must complete a form (PM 330) attesting that they are giving informed consent for sterilization services. The form can be located by visiting the following site: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/8425F804-9243-468F-BC06-4331EF7907B4/ster.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO. KP has internal processes for the completion of the PM 330 form. Please refer the patient to their PCP for further assistance. KP has internal processes for the completion of the PM 330 form. Please refer the patient to their PCP for further assistance. MMC Members may not waive the 30-day waiting period for sterilization.

Telehealth

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a MMC Member's health care. Telehealth facilitates MMC Member self-management and caregiver support for MMC Members.

Providers may provide Telehealth services to its MMC Members. The Provider must assess the appropriateness of the Telehealth modality to the MMC Member's level of acuity at the time of the service. Before the delivery of health care via Telehealth, the Provider initiating the use of Telehealth shall inform the MMC Member about the use of Telehealth and obtain verbal or written consent from the MMC Member for the use of Telehealth as an acceptable mode of delivering health care services and public health. The consent must be documented in the MMC Member's medical record.

Transportation / Travel and Lodging

In addition to emergency medical and non-emergency ground/air ambulance, KP covers non-emergent medical transportation (NEMT), and non-medical transportation (NMT) at no cost for KP-Assigned MMC Members and travel and lodging expenses related to NEMT.

- **Non-Emergent Medical Transportation (NEMT)**: Medical Transportation in non-emergency situations if MMC Member has medical needs that do not allow them to use a car, bus, train, or taxi to get to their Medi-Cal appointments. These services must be prescribed by a provider. Medical Transportation must be used when MMC Member is a Medi-Cal member and:

    - Not able to physically or medically use a bus, taxi, car or van to get to their appointment
    - They need help from the driver to and from their residence, vehicle or place of treatment due to a physical or mental disability

    Criteria for NEMT modality:

Wheelchair Van	Litter (Gurney) Van	BLS Ambulance
MMC Member requires: • Specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance • Is incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport • Requires to be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation	MMC Member requires: • To be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport • Specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance	MMC Member requires: • Continuous Intravenous Medication • Special Positioning Requiring EMT Supervision • Chemical Restraints • Acute Oxygen Need (Note: does not apply to MMC members with chronic emphysema who carry their own oxygen for continuous use) • Physical Restraints • Airway Monitoring (Aspiration Precautions) • Quarantine / Isolation • Supervision to Prevent Harm to Self or Others • Deep Suctioning **Note**: BLS should only be ordered if the patient meets the above clinical criteria

NEMT services must be prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender. Telephone authorizations for service requests requires a medically necessary service of urgent nature. Providers decide the correct type of transportation that a MMC member may need. Medical Transportation can be an ambulance, litter van, wheelchair van or air transport. If approved for services, MMC Members will receive a letter in the mail with details on how to schedule their transportation.

The order is valid for up to one (1) year from the date of the provider's signature. If the NEMT Referral Order is initiated/signed by a staff member other than below, a co-sign is required:

- Physician
- Dentist
- Podiatrist
- Physician Assistant
- Nurse Practitioner
- Certified Midwife
- Psychologist
- Mental Health Licensed Social Worker (LCSW)
- Behavioral Health Licensed Social Worker (LCSW)
- Chemical Dependency Licensed Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)

For additional information resources regarding NEMT Referral Order: 1-800-464-4000.

- **Non-Medical Transportation (NMT)**: NMT is available to all MMC Members requiring round-trip transportation to covered medical appointment or services, including lab work, X-rays, pharmacy, and any Medi-Cal Covered Services. Unlike NEMT, clinical authorization/medical necessity by the MMC Member's Provider is not required. NMT services are available for KP assigned MMC Members when the MMC Member has no other way to get to their scheduled appointment or service and when the MMC Member can ambulate without help from the driver.

  KP covers MMC Members using a car, taxi, bus or other public/private way to get to their medical appointment for Medi-Cal-Covered Services. KP covers the lowest cost NMT type that still meets medical needs. Sometimes, KP can reimburse MMC Members for rides in a private vehicle that they arrange. This must be approved by us before the ride. MMC Members must tell us why they cannot get a ride in other ways, such as the bus. KP will not reimburse MMC Members for using a transportation broker, bus passes, taxi vouchers, or train tickets. To request authorization and the criteria used to make authorization decisions call KP's transportation provider at 1-844-299-6230 (TTY 711). The representative can also answer any questions about mileage reimbursement.

  - For routine appointments, please call Kaiser Permanente's transportation provider at 1-844-299-6230 (TTY 711) at least three business days (Monday through Friday 5 a.m.-7 p.m.) before your appointment.

  - For urgent requests, including being discharged from the hospital, call for a ride 24 hours a day, 7 days a week.

- **Travel and Lodging (Covered Services)**: KP will cover some travel related expenses for medically necessary services that are more than 100 miles from the MMC Member's home. KP could also cover someone who is traveling with the MMC Member to help them with their appointment or for someone who is donating an organ to them for an organ transplant.

- Lodging and meal arrangements must be located within a reasonable distance from the location where the MMC Member will obtain medically necessary services.

- KP will reimburse MMC Members for approved travel expenses incurred by the MMC Member and accompanying attendant, if applicable, for one (1) room plus tax, up to $200 per day. They will use the IRS per diem rates to provide reimbursement for approved meal expenses if those expenses are supported by receipts.

MMC Members may be able to get help with travel expenses, such as transportation, meals, lodging parking, tolls, if they do not have a way to get to medical appointment for a CCS qualifying condition.

For more details call Travel and Lodging Coordinators at the number listed here: Southern California Travel and Lodging Coordinator at (626) 405-6162.

MMC Members may also contact the Member Services Call Center at 1-855-839-7613 for assistance with questions regarding NEMT, NMT or travel/lodging benefits.

Vaccine for Children Program (VFC)

Providers serving MMC Members under the age of 19 may be eligible to participate in the Vaccine for Children Program (VFC). The VFC program provides all routine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to the participating healthcare provider. Providers can contact their state/local/territory VFC coordinator to request enrollment at CDC Centers for Disease Control and Prevention, Vaccines for Children Program (VFC): https://www.cdc.gov/vaccines-for-children/hcp/program-eligibility/index.html#cdc_generic_section_4-medicaid-providers-can-enroll-in-the-vfc-program

Vision Benefits

- **Eye Exams**: All MMC Members are eligible for a routine eye exam and eyeglasses once every 24 months.

  MMC Members are covered for eye exams to determine if they need eyeglasses and to provide a prescription for eyeglasses. Please direct any MMC Member requests for the services listed below to KP's Member Services Call Center at 1-855-839-7613 for scheduling assistance.

- **Eyeglasses, Lenses, and Frames**: Eyeglasses (frame and lenses) may be covered every 24 months when a MMC Member has a prescription of at least 0.75 diopter. MMC Members should check their Evidence of Coverage annually to confirm benefit.

  KP must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all MMC Members. KP must arrange for the fabrication of optical lenses for MMC Members through Prison Industry Authority (PIA) optical laboratories except when the MMC Member requires lenses not available through PIA. KP must cover the cost of the eye

examination and dispensing of the lenses fabricated by PIA. KP must cover the cost of fabrication and dispensing of lenses not available through PIA.

MMC Members must seek Medi-Cal vision services, including eyeglasses (frame and lenses) benefits, through in-network providers who accept Medi-Cal managed care plans or Fee-for-Service Medi-Cal.

- **Special Contact Lenses**: Contact lens testing may be covered if the use of eyeglasses is not possible due to eye disease or condition (i.e., missing an ear).

  KP may cover contact lenses under certain conditions:
  - For aniridia (missing iris), up to two medically necessary contact lenses (including fitting and dispensing) per eye every 12 months at no charge.
  - One pair of medically necessary contact lenses (other than contact lenses for aniridia) every 24 months at no charge. Contact lenses are covered only if a KP plan Provider or KP plan optometrist finds that they will give a MMC Member much better vision than they could get with eyeglasses alone. We cover replacement of medically necessary contact lenses within 24 months if a MMC Member's contact lenses are lost or stolen.

- **Other Vision Services**
  - Low vision testing for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine or surgery that interferes with a person's ability to perform everyday activities (i.e., age-related macular degeneration).
  - Artificial eye services and materials for those individuals that have lost an eye or eyes to disease or injury.

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 annual DMHC and the quarterly 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. You are required to provide your appointment availability during these surveys as part of your contractual agreement.

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 Care Experience, 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)	
	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	5 Business days

APPT CATEGORY	DEFINITION	KP INTERNAL STANDARD
	resolved. Appointment requests in 8 weeks or less from last visit.	
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 impaired ability to function in normal roles at home, work, or school	b. 24 hours
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.
- Member Experience Tracking Evaluation and Opinion Research (METEOR) – also known as the CAHPS off-cycle monitor, METEOR is an internal version of CAHPS conducted on a monthly basis and reported at the region and medical center area level to monitor our performance on strategic service goals as well as to anticipate our performance on CAHPS.

The results from both of these 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 KP SCAL service improvement goals and to compare member experiences with health plans across the nation.

The latest KP SCAL Commercial CAHPS results and National and Pacific percentile rankings from the 2024 Quality Compass were publicly released in the summer of 2024. These results will be used to evaluate opportunities for improvement and guide strategic service and access (care experience) goals for the 2025 performance year.

	2024 KP-SCAL Score	**2024 KP-SCAL National Percentile** Ranking	**2024 KP-SCAL Pacific Percentile** Ranking
Overall Ratings			
Rating of All Health Care (%9+10)	**46.1%**	**33rd**	**50th**
Rating of Health Plan (%9+10)	**50.2%**	**75th**	**75th**
Rating of Personal Doctor (%9+10)	**62.9%**	**10th**	**33rd**
Rating of Specialist Seen Most Often (%9+10)	**63.2%**	**25th**	**25th**
Composite Measures			
Getting Needed Care Composite	**74.0%**	**<5th**	**33rd**
Getting Care Quickly Composite	**67.5%**	**5th**	**25th**
Personal Doctor Communication Composite	**90.9%**	**5th**	**10th**
Claims Processing Composite	**NA**	**NA**	**NA**

	2024 KP-SCAL Score	2024 KP-SCAL National Percentile Ranking	2024 KP-SCAL Pacific Percentile Ranking
Care Coordination	**83.3%**	**33rd**	**50th**
Customer Service Composite	**86.5%**	**33rd**	**33rd**

For the 2024 performance year, 2023 CAHPS and Patient Assessment Survey (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, 2023 CAHPS Pacific 75th percentile, 95.25%.
2. Getting care quickly composite (CAHPS) – to achieve the external benchmark, 2023 CAHPS Pacific 75th percentile, 78.57%.
3. Getting needed care composite (CAHPS) – to achieve the external benchmark, 2023 CAHPS Pacific 75th percentile, 80.17%
4. Overall rating of specialist (CAHPS) – to maintain the external benchmark, 2023 CAHPS Pacific 75th percentile, 67.26%.
5. Office Staff composite (PAS) – to achieve the external benchmark, 2023 PAS 90th percentile, 79.85%.

Kaiser Permanente monitors and evaluates our progress on the above measures, as available, on an ongoing basis. 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 (http://www.opa.ca.gov/) and the NCQA health insurance plan ratings (https://reportcards.ncqa.org/).

New Technology

Kaiser Permanente (KP) has an established, rigorous process for evidence-based medical technology assessment. In the Southern California Region, the Medical Technology Management Process (MTMP) provides an ongoing structure for the evaluation of select new and existing medical technologies that impact the Southern California region. The MTMP is coordinated by executive leaders from operations, scientific evidence review and appraisal (Medical Technology Assessment Team) and product selection and sourcing (Regional Product Council). MTMP ensures that recommendations 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 MTMP works 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 KP Interregional New Technologies Committee (INTC), which evaluates the evidence basis of new medical technologies of interest to all KP regions.

For additional information on Kaiser Permanente Southern California's medical technology assessments, please send and email to SCAL-MEDICAL-TECHNOLOGY-MGMT-PROCESS@kp.org.

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 Permanente Member Resource Guide
- Visiting http://www.kp.org/

NCQA Accreditation

Since 1995, 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. In July 2021, the state legislature passed AB 133. The new law designated NCQA as the required and sole accreditor of California's commercial plans. That means three of the four California public sector agencies officially require NCQA Health Plan Accreditation (HPA) for the plans they regulate.

The last **Health Plan Accreditation (HPA)** survey for KFHP was conducted in March 2023 for which the Commercial, Exchange, and Medicare HMOs received an "Accredited" status. This means Kaiser Foundation Health Plan (KFHP) Southern California met NCQA's strict evaluation and rigorous requirements in the areas of quality management, network management, utilization management, population health management, member experience, physician credentialing, and improvement initiatives. The next NCQA HPA renewal survey is scheduled for September 2025.

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 107 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 **Health Equity Accreditation (HEA)** as of July 2024. This achievement demonstrates the excellence of Kaiser's Equity, Inclusion and Diversity program and reflects the continuous quality improvement efforts taken by KFHP to advance health equity and ultimately accomplish a more equitable health care system. Health equity accreditation is focused on the following five categories: Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Data, Access and Availability of Language Services, Practitioner Network Cultural Responsiveness, Culturally and Linguistically Appropriate Services Programs, and Reducing Health Care Disparities. The next NCQA HEA renewal survey is scheduled for April 2027.

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 Dual Complete Program

also known as Special Needs Plan (SNP)

Provider Annual Model of Care Compliance Training

kp.org/choosebetter

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Kaiser Permanente (KP) Dual Complete (D-SNP)

- In the Medicare Modernization Act of 2003 (MMA), the Federal Government created a new type of Medicare Advantage (MA) plan, called a Special Needs Plan (SNP), for individuals with complex, high cost, and high medical needs.
- Three types of SNPs were authorized for specific populations:

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) currently only offers a D-SNP plan.
- Members must elect to enroll in the D-SNP plan.
- **Effective January 1, 2025, KP will rebrand the D-SNP line of business (plan) name to Kaiser Permanente Dual Complete**.

Kaiser Permanente (KP) Dual Complete (D-SNP)

Each Southern California Kaiser Permanente Service Area has a Dual Complete Interdiciplinary Care Team (ICT) with a lead local case manager who provides care management and coordinates Medicare and Medicaid covered benefits or services, such as:

- Long-Term Services and Supports (LTSS) (Medicaid)
  - e.g. CBAS, IHSS, MSSP and LTC
- Denti-Cal (Medicaid)
- $350 allowance for eyeglasses, lens, and contacts purchased at Vision Essentials network providers, once every 12 months (Medicare supplemental benefit)
- $200 quarterly benefit limit OTC products purchased through our OTC catalog through our network provider. Products may be purchased online, by phone or mail-order (Medicare supplemental benefit)
- $0 gym membership for fitness services through the One Pass® fitness program. Includes core and premium network of fitness centers, digital fitness offerings, home fitness kit, brain health program, and more (Medicare supplemental benefit)
- Medically tailored meals program(s) (Medicaid and Medicare)
- Other Community Based Case Management (CBCM) and Community Supports (CS) services (Medicaid)

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Why Medicare established SNP:

- Improve coordination and continuity of care by regularly assessing patients' needs
- To proactively identify patients' needs and coordinate enhanced benefits available through Medicare and Medi-Cal

What are the Goals of a SNP?

The SNP goals are to improve member care and quality in the following areas:

- Health outcomes
- Access to medical, mental health, and social services
- Access to affordable care
- Coordination of care through an identified point of contact
- Transitions of care across health care settings
- Access to preventive health services

Who are KPSC SNP or Dual Complete Members:

- They are Medicare Dual Complete members with Medi-Cal
  - Also known as Medi-Medi members

- KPSC has approximately 53,000 Dual Complete members and is expected to continue to grow in 2025
- Based on information obtained both from self-reported data in the Health Risk Assessment and through patient clinical history, a Dual Complete member is likely to:
  - Be female (62%)
  - Be Hispanic (51%)
  - Be age 65 or older 80%)
  - Live with their children or other relative (33%)
  - Use Spanish as their primary spoken language (45%)
  - Experience multiple chronic conditions
    - 50% have more than four (4) comorbidities
    - 70% suffer from hyperlipidemia disease
    - 30% suffer from mood (affective) disorders

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Disease Prevalence in the KPSC Dual Complete Population:

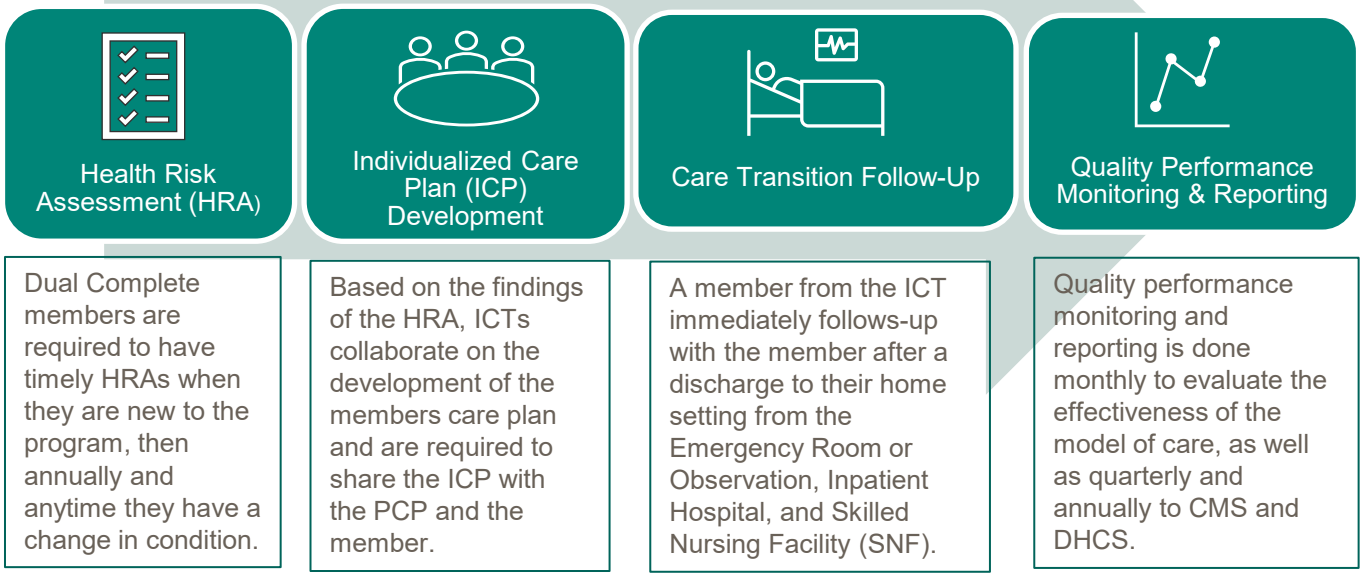
The top 3 prevalent conditions in the KPSC Dual Complete population include:

Age 65 and older	Under age 65
1. Hyperlipidemia (78%) 2. Hypertension (75%) 3. Diabetes (48%)	1. Hyperlipidemia (55%) 2. Hypertension (46%) 3. Depression, Bipolar, or other Depressive Mood Disorders (40%)

Dual Complete or SNP Model of Care Workflow

Kaiser Permanente's integrated model, along with its electronic medical record, KP HealthConnect (KPHC), drives collaboration amongst Dual Complete Interdisciplinary Care Teams (ICT). Members are assigned to an ICT based on their PCP location. ICTs are locally located at 13 KP service areas in SCAL and include the patient, caregiver(s), patient's primary care physician, specialty physicians, SNP care manager, behavioral health providers, laboratory imaging services, and pharmacy services, all of which are integrated under one "roof" as part of the KP program.

Kaiser Permanente (KP) Dual Complete Interdisciplinary Care Teams (ICT) Workflow



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What is the role of the physician?

- 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 important members of the Dual Complete member's Interdisciplinary Care Team (ICT)
- The Dual Complete Care Team will contact the PCP for orders or for other needs identified for the members, including DME, supplies, referrals to community programs, pharmacy recommendations.
- The Dual Complete Care Team will route the care plan to the primary care physician in KPHC (if no new recommendations), in accordance with Medicare guidelines.
- Specialty care providers will be included in the care coordination of the patient as appropriate
- Per Medicare guidelines, all KPSC providers must complete the annual SNP Model of Care training

Dual Complete Interdisciplinary Care Team

- Dual Complete patients are assigned to an Interdisciplinary Care Team (ICT) to manage care based on their PCP Location
- 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

