Kaiser Permanente Northwest Provider Manual 2018

Medicare Advantage

We created this section of the provider manual to guide you and your staff in working with Kaiser Permanente's Medicare Advantage policies and procedures. It provides a quick and easy resource with contact phone numbers, detailed processes, and site lists for Medicare Advantage services.

If you have a question or concern about the information in this manual, contact our provider relations department at 503-813-3376.

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Section 9: Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) requires all providers and facilities of Northwest Permanente (NWP) and Kaiser Foundation Hospitals (KFH) who are contracted to provide services to Kaiser Permanente Northwest (KPNW) members to meet the requirements created by the Balanced Budget Act of 1997 that govern Medicare Advantage plans, like Kaiser Permanente Senior Advantage Medicare Advantage plan.

Below are requirements you must follow as a provider for Senior Advantage members. Some requirements are mentioned in the standard KPNW provider agreement and may be duplicated in these chapters. Some requirements are mentioned only in this chapter. Please read each chapter carefully to understand your obligations as a contracted practitioner. The discussion below each requirement elaborates on the contract provision or requirement and offers insight about how to apply the requirement.

If there is a conflict between this provider manual and your Agreement, the terms of your Agreement will control.

Policies and procedures that appear elsewhere in this guide that relate to a specific requirement have been cross-referenced. Please consult all cross-references.

9.1 Member Rights

Access to Services

Provider must provide services during hours of operation that are convenient to members and do not discriminate against members. Provider must make provide all information about treatment options to members in a culturally competent manner, including the option of no treatment. Provider will ensure that members with disabilities will be able to communicate effectively with all health care professionals in deciding on treatment options.

Access to benefits must be provided to Senior Advantage members in a manner described by CMS, such as during hours of operation. In addition, KPNW monitors its provider network to make sure adequate access to covered services is maintained. We will survey members regularly to help assess the accessibility of services and the adequacy of the provider network. These survey results help KPNW evaluate the performance of its providers.

Advance Directives

Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive. Providers shall not condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive.

Information about advance directives must be provided to all adults and be documented in a prominent place in the medical record whether or not one has been executed. Advance directives are formal documents signed by a patient that explain the patient's wishes about medical care in case he or she is unable to make these wishes known.

Confidentiality

Provider must ensure the confidentiality and accuracy of the medical records or other health and enrollment information of members. They must also abide by all federal and state laws on confidentiality and disclosure of mental health records, medical records, or other health or membership information. Providers shall not sell, release, or otherwise disclose the name or

address of any member to any third party for any purpose, including scientific study.

Additionally, providers must maintain such records in an accurate and timely manner and ensure timely access to members who wish to examine their records. Confidential patient information protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

Discrimination Prohibited

Providers shall not discriminate against members on the basis of any factor prohibited by law, including but not limited to health status, mental condition (including mental or physical illness) claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Providers may not discriminate against any KPNW member on the basis of race, religion, or any other factor prohibited by law. In addition, providers must not discriminate in the providing medical services for Senior Advantage members on the basis of health status. Providers must not restrict their practice to individuals perceived to be healthy or refuse to accept any member as a patient on the contention that the payment methodology would not compensate them for providing services to this population.

9.2 Provider Rights and Responsibilities

Adherence to Grievance and Appeals Procedures

Provider shall cooperate and abide by KPNW's grievance and appeals procedures for members, including, upon KPNW's request, the gathering and forwarding of information on such grievances, and appeals to KPNW within timeframes required by KPNW.

Medicare has developed an appeals process to help members resolve disputes on coverage determinations related to their Part C Medical Services and Benefits, as well as their Part D Prescription Drug Benefit.

Grievances and appeals procedures can be found at http://www.providers.kaiserpermanente.org/html/cpp_knw/memrights.html?

Adherence to CMS Laws, Regulations and Instructions

Provider shall comply with the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act, ACA 1557, and all other laws applicable to recipients of federal funds, and all other applicable laws, regulations, and rules.

Providers and all their subcontractors must comply with all applicable Medicare laws, regulations, and CMS instructions. Any provision required to be in this Agreement by the rules and regulations governing the Medicare Advantage program shall bind the parties whether or not provided in this Agreement. In addition, to the extent applicable, providers must comply with the obligations in the contract between CMS and KPNW governing KPNW's participation in the Medicare Advantage program.

KPNW is a Medicare contractor and is therefore a recipient of federal payments. As a contractor of an organization that receives federal funds, you are subject to the same laws applicable to individuals and entities that receive federal funds. You and your subcontractors must comply with all rules and regulations that are applicable to federal contracts. These include the specific laws noted above, general rules that might apply, and policies, procedures, guide provisions,

and other program requirements issued by CMS. These also include KPNW's policies and procedures apply to providers.

Compliance with Policies and Programs

Providers must comply with KPNW's medical policy, quality assurance program, and medical management program.

You must review, participate in, and comply with KPNW's medical policy, quality assurance program, and medical management program.

See the Quality Assurance section in your provider manual.

Continuation of Services after Termination

Provider must continue to provide services to Senior Advantage members who are hospitalized through the later of (a) the date for which premiums were paid or (b) through the date of discharge, even if the contract between CMS and KPNW has ended or in the event of the insolvency of KPNW. Provider is legally prohibited from billing Senior Advantage members for such services.

Providers acknowledge that services to Senior Advantage members won't be interrupted should KPNW go bankrupt, is unable to pay its debts, or terminates its contract with CMS or another provider. Services must continue through the end of the month in which CMS makes its last payment to KPNW for the member. In cases when the member is hospitalized, the obligation to provide services continues until discharge.

Cooperate with Independent Quality Review

Providers must cooperate with any independent quality review and improvement organization or other external review organization retained by KPNW as part of its quality assessment and improvement program.

Quality review is a material part of KPNW's contract with CMS. You must participate in quality review and any quality review function KPNW designates.

Cultural Competence

Providers must provide services in a culturally competent manner to all members. Kaiser Permanente expects you to provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Delegation

If KPNW has delegated any core activity or function (as defined by CMS) to a contracted practitioner; the activity or function must be monitored and overseen by KPNW.

In its agreements with providers, KPNW will specify delegated activities and reporting responsibilities, termination procedures if the provider doesn't perform the function as required, and KPNW's right and responsibility to perform ongoing monitoring. To the extent that KPNW has delegated any activities or functions, providers will make such periodic and other reports as reasonably required by KPNW.

Disclosure of Quality and Performance Indicators

Providers must disclose to CMS the quality and performance indicators for benefits under the Senior Advantage plan regarding member satisfaction and health outcomes.

KPNW conducts ongoing studies and surveys of member satisfaction and health outcomes. You must participate in these studies and surveys as requested by KPNW.

Follow-Up-Care and Training in Self Care

Providers must provide members with information on follow-up care, as well as training on such subjects as self-care, medication management, use of medical equipment, potential complications and when to report them to providers, and scheduling follow-up services.

Marketing Material

All forms of written or electronic marketing materials must be reviewed and approved by CMS.

"Marketing materials" include those used to promote KPNW or Kaiser Permanente Senior Advantage, inform Medicare members and beneficiaries about enrollment, explain coverage of benefits, and explain coverage of Medicare services. Materials will usually be developed, produced, and disseminated by KPNW. If providers or provider groups develop informational materials to inform Medicare patients about KPNW, Senior Advantage, or its services, they must submit these materials to KPNW for review and approval. Marketing materials developed by providers that are intended for Senior Advantage members or other Medicare beneficiaries require CMS approval.

No Recourse against Member

Providers agree that in no event, including but not limited to, nonpayment by KPNW, insolvency of KPNW, cessation of operations by KPNW, or breach of this Agreement, will the provider bill, charge, collect a deposit from, impose surcharges, or have any recourse against a member or a person acting on behalf of a member for services provided pursuant to this Agreement. This Agreement doesn't prohibit providers from collecting (a) coinsurance, deductibles, or copayments, as specifically provided for in KPNW's Service Agreement or (b) fees for non-covered services. Nor does this Agreement prohibit providers and members from agreeing to continue services solely at a member's expense, as long as the provider has clearly informed the member that KPNW might not cover or continue to cover a specific service or services.

CMS requires that Medicare Advantage members be protected from incurring financial liability for charges that are the obligation of KPNW to pay. Providers must look solely to KPNW for the cost of covered services provided to Senior Advantage members. Senior Advantage members are liable only for cost-sharing amounts that are specified in KPNW's membership contract.

Please see the Hold Harmless section in your contract Agreement.

Notice and Hearing Rights

If KPNW suspends or terminates this Agreement and gives written notice of such to the contracted practitioner, the provider will have the rights to notice and a hearing as required by the Medicare Advantage statutes, rules, and regulations. The provider must give each physician who is entitled to notice and a hearing under the Medicare Advantage Program written notice of such suspension or termination. It must include notice of the right to appeal and the process and timing for such appeal or reference to KPNW's notice and hearing procedures. Notwithstanding any rights of appeal, the suspension or termination will be final within the period stated in such notice to contracted practitioner. Nothing stated herein shall prohibit KPNW from contracting with other providers to provide services under this Agreement, and the provider will have no

claim against KPNW if it exercises this right. If the provider is not an individual physician, it will have no rights of appeal.

If KPNW suspends or terminates an agreement for services with an individual contracted practitioner, KPNW will provide notice of hearing rights as required by the Medicare Advantage statutes, rules, and regulations. With contract terminations involving a provider group or organization, the group or organization must give each affected physician who is entitled to notice and a hearing under the Medicare Advantage program written notice of such suspension or termination. The notice must include notice of the right to appeal, the process and timing for such appeal, and reference KPNW's notice and hearing procedures. Any such rights of appeal won't delay the date of suspension or termination. Rights of appeal and hearing are available only to individual physicians.

See Notice and Hearing Rights in the Patient Rights section of your provider manual.

Notice of Termination of Contracted Providers

Senior Advantage members must be notified (by the provider) of the termination of a provider with whom they regularly received care.

KPNW intends to notify affected members within 15 days of the date of notice of termination. Terminated providers must provide KPNW with the information needed to meet this notice obligation.

Payment and Incentive Arrangements

Payment arrangements between KPNW and its providers must be set forth in contracts. Your contract specifies our payment arrangements. In addition to our contract with you, all subcontracts you enter into with other individuals or entities that provide health care services to Senior Advantage members must specify payment arrangements. No contract provision, payment or otherwise, can create an incentive to reduce or limit services to a specific member.

Professionally Recognized Standards of Care

Providers must provide services to members in a manner consistent with professionally recognized standards of care.

Prohibition against Contracting with Sanctioned and Opt Out Providers

Providers must not employ or contract with directly or indirectly, any individual or entity excluded from participation under Medicare or who has opted out of Medicare for the provision of health care services, utilization review, medical social work, or administrative services with respect to members. As part of the credentialing process, providers must get certification from each physician and any other health care professionals providing services that they haven't been excluded from participation under Medicare nor has opted out of Medicare.

KPNW is prohibited from employing or contracting with providers excluded from participation in (sometimes referred to as "sanctioned providers"), or who have opted out, of Medicare. Providers are also prohibited from employing or contracting with such providers. Contracts are terminable for these reasons. Providers must certify to KPNW that its contractors are eligible to participate in Medicare and must notify KPNW if it discovers such a provider is under its employ.

Prompt Payment of Compensation

When applicable, payments by KPNW or its designee shall be made in accord with the member's health care benefits.

KPNW or its designee shall pay, and provider agrees to accept as payment in full, the all-inclusive rates listed herein, less any applicable member copayments, for services provided to Members pursuant to the terms of this Agreement.

In cases where Kaiser coverage is primary, KPNW or its designee will pay for services or provide notice of denial within thirty (30) working days of receiving a properly completed provider bill and any other necessary forms as required by KPNW.

Interest on any late payments will be paid as required by law.

Payment provisions, including a provision for timely payment, are set forth in your contract. Any subcontracts you have with providers or entities that will provide services to Senior Advantage members must likewise contain a prompt payment provision.

Requirements Binding on Contracted Practitioner's Subcontractors

If a provider arranges for the provision of any covered services from other health care providers, that provider must include in its contracts with such providers all contractual and legal obligations required by the laws, regulations, rules, and directions of CMS as they apply to services to be provided by such providers. To the extent that CMS requires additional provisions be included in such subcontracts, the provider must amend its contracts accordingly.

KPNW generally contracts directly with providers. However, in limited instances providers subcontract for care provided to Kaiser Permanente.

Senior Advantage members. KPNW requires that specific provisions be included in subcontracts. KPNW will provide guidance about the specific provisions that must be included in your contracts with other providers serving Senior Advantage members.

Termination as to Medicare Advantage Members

If the Medicare Advantage contract between CMS and KPNW is terminated or not renewed, this Agreement will be terminated as to Medicare Advantage members unless CMS and KPNW agree otherwise. Such termination as to Senior Advantage members must be accomplished by delivery of written notice by the medical group to the provider of the date when the termination will become effective.

Since CMS may choose to terminate its contract with KPNW, KPNW must be able to terminate the Medicare Advantage provisions in its provider contracts without breach or termination of the remainder of the contract. Likewise, KPNW may choose to non-renew its contract with CMS. Generally, CMS will notify KPNW 90 days before it intends to terminate its contract with KPNW, while KPNW must notify CMS by a specified date the year before KPNW intends to non-renew its contract.

Terminations without Cause

Either party may terminate this Agreement at any time, with or without cause, by giving sixty (60) days written notice to the other party.

To ensure stability and continuity in services for Senior Advantage members, CMS requires that KPNW and its providers provide each other with at least 60 days written notice before terminating a contract without cause, if the contract contains a "termination without cause" provision. This requirement doesn't amend any contract with no "termination without cause" provision; nor does it shorten a notice period for a termination without cause if the period of time specified in the contract is greater than 60 days.

9.3 Recordkeeping and Reporting

Certification of Data

Providers recognize that as a Medicare Advantage organization, KPNW is required to certify the accuracy, completeness, and truthfulness of data that CMS requests. This data includes encounter data, payment data, and any other information provided to KPNW by its contractors and subcontractors. Providers and their subcontractors hereby represent and warrant that any such data submitted to KPNW will be accurate, complete, and truthful. Upon request, providers must make such certification in the form and manner prescribed by KPNW.

You and your subcontractors must certify the completeness and truthfulness of the data you provide to KPNW. This data is subject to audit by KPNW or CMS.

Disclosure of Information to CMS

KPNW and its providers must disclose all necessary information to allow CMS to administer the Medicare Advantage program and inform members and prospective members about their choices for coverage under the Medicare program.

Providers must provide KPNW and/or CMS with all information necessary for CMS to administer and evaluate the Medicare Advantage program. You must cooperate with KPNW in providing CMS with the information needed to establish and facilitate a process to enable current and potential beneficiaries to make informed decisions with respect to Medicare coverage.

Encounter Data

For members for which providers receive compensation under this Agreement, the provider must provide KPNW with the properly completed CMS-1500 form or its successor format, for each encounter at a provider location where a member received approved services. This information must be complete, accurate, and provided to KPNW within thirty (30) days from date of discharge. Encounter reporting shall be in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 3.0, or its successor. Additionally, the provider must promptly provide KPNW with all corrections to and revisions of such encounter data.

You must submit to KPNW complete, accurate, and timely data, including medical records, necessary to characterize the content and purpose of each encounter with a member. You must submit data in the format prescribed by KPNW. We'll conduct periodic random audits for coding completeness and accuracy. Complete and accurate coding prevents fraud and abuse. If you have questions about this process, please contact us.

Maintenance and Audit of Records

Providers must maintain, and make available to KPNW, the Department of Health and Human Services, the Comptroller General, or their designees, for evaluation, audit, and inspection any relevant contracts, books, documents, papers, and records, including but not limited to, medical records and patient care documentation, related to this Agreement for six (6) years from the final date of the Agreement or from any audit's date of completion, whichever is longer, or longer if required by CMS.

CMS evaluates the quality, appropriateness, and timeliness of services provided to Kaiser Permanente Senior Advantage members, facilities used to deliver services, and other functions and transactions. A provider must have books and records to support all services provided to Senior Advantage members. CMS has changed the timeframe for retention of records to include

six years from the date of an audit. Providers and their related entities, including subcontractors, are required to have records available for a six-year period after you or KPNW terminates its contract with CMS or completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS).

9.4 Provisions that Apply to Primary Care Physicians

The following additional provisions apply only to providers who have primary responsibility for the coordination of care provided to KPNW's Senior Advantage members.

Access to Specified Vaccines

All members shall have direct access for influenza vaccines. Members shall not be required to pay for influenza and pneumococcal vaccines.

Members do need not a referral or prior authorization to get influenza vaccines. In addition, copayments (including office visit copayments) cannot be collected for influenza or pneumococcal vaccines. Members must be able to access these services without charge. If, however, other services are received at the same time, then the provider can charge members the applicable office visit copayment. For example, a member who makes an appointment for a physical exam can be charged an office visit copayment for that exam, even if they receive an influenza or pneumonia vaccine during the exam.

Complex or Serious Medical Conditions

Providers must establish a treatment plan that identifies any complex or serious medical condition, provides for assessment and monitoring of those conditions, and allows for the implementation of a treatment plan for those conditions. This includes recommendations about medically necessary and appropriate care from specialists and an adequate number of direct access visits. The treatment plans must provide for consideration of the Senior Advantage member's input, be time-specific, and get updated periodically.

Providers who are responsible for primary care must comply with KPNW's guidelines for the identifying and treating members with complex or serious medical conditions. Individuals with serious or complex medical conditions must be identified, their condition assessed and monitored, and appropriate treatment plans implemented.

Direct Access to Women's Health Specialist and Mammography Screening

Female Senior Advantage members must have direct access to a women's health specialist within the network for routine and preventive women's health care services provided as basic benefits. Women's health specialists are defined as gynecologists, certified nurse midwives, or other qualified health care providers. Women's health services include pelvic exams, Pap smears and mammography screening.

Female members often access their women's health specialist like a primary provider. Thus, to ensure continuity of care, female members must have continued access to a primary care provider, or mechanisms must exist that ensure referral beyond the women's health specialist occurs when needed.

Frequency guidelines under Medicare allow female Senior Advantage members age 40 and older to receive annual screening mammography. Providers must allow female Senior Advantage members age 40 and older to self-refer for mammography screening to providers contracted with KPNW.

Initial Health Assessment

Providers who have primary responsibility for the coordination of care provided to KPNW's Senior Advantage members must make an initial assessment of each member's health care needs and for coordinating care. Assessments must be performed consistent with any guidelines developed by KPNW.

Primary care physicians must conduct an initial health assessment of all new Senior Advantage members within 90 days of the effective date of membership. KPNW will choose the form and substance of the initial assessment. The process for notifying providers when new members are enrolled will be defined by KPNW.