KAISER FOUNDATION HEALTH PLAN OF COLORADO

2019 Access Plan
Denver/Boulder Service Area

1. INTRODUCTION

Kaiser Foundation Health Plan (KFHP) of Colorado
Carrier Network ID Number: CON001
Full Name of Network: Kaiser Permanente Denver/Boulder

Kaiser Foundation Health Plan (KFHP) of Colorado is Colorado's oldest health maintenance organization. The KFHP of Colorado and the Colorado Permanente Medical Group (CPMG) have an exclusive relationship for the provision of health care services. CPMG is a multi-specialty physician group made up of primary care and specialty care physicians.

Kaiser Permanente owns and operates 22 medical offices and five mental health offices in the Denver and Boulder metropolitan areas. Weekday hours vary across medical offices, and current information can be found at **kp.org/locations**. On weekends, Aurora Centrepoint, Lakewood, and Lone Tree Medical Offices are open for urgent care. Aurora Centrepoint, Lakewood, and Lone Tree Medical Offices are open on Saturday and Sunday from 8 a.m. to 6 p.m.

In addition to using any of the Kaiser Permanente medical offices in the Denver/Boulder service area, members are also able to access routine services at: Briargate, Parkside, Acero, and Pueblo North Medical Offices in Southern Colorado and Loveland, Fort Collins, Greeley, and Spring Creek Medical Offices in Northern Colorado.

The Kaiser Permanente website, **kp.org**, provides a list of CPMG physicians and their specialties. Members may also request a list of physicians and specialties by calling Member Services at **303-338-3800** (TTY **711**) Monday through Friday, from 8 a.m. to 6 p.m.

Kaiser Permanente encourages members to select a Primary Care Physician (PCP) in family medicine, internal medicine, or pediatrics upon becoming a member. Members may change their physician at any time, for any reason. If the member needs specialized care, the PCP assists in coordinating that member's care with a referral to a specialist.

All members are able to access the Kaiser Permanente network for primary care and specialty care services through the Appointment and Advice Contact Center. Members can call **303-338-4545** (TTY **711**) 24 hours a day, 7 days a week. Members can call that same number for medical advice. Most of the time, members are seen the same day or at least within 14 days from the time that they call. Appointments and advice are also available through Kaiser Permanente's website, **kp.org.**

Kaiser Permanente maintains one electronic record for each member seen at a Kaiser Permanente office. The medical record is available to all physicians in Kaiser Permanente medical offices and portions of this record are also available to registered members through secure access at **kp.org**.

Members are encouraged to call the Appointment and Advice Contact Center after normal business hours for medical advice or to seek care at one of the Kaiser Permanente Urgent Care or Children's Hospital Urgent Care locations. Or, in an emergency and if time and safety permit, members are encouraged to seek care at one of the following contracted facilities: SCL Health Saint Joseph Hospital, SCL Health Good Samaritan Medical Center, SCL Health Saint Joseph Emergency Littleton, SCL Health Saint Joseph Emergency Aurora, HealthONE Sky Ridge Medical Center, HealthONE Swedish Medical Center, Children's Hospital Colorado–Main Campus, Children's Hospital Colorado at Parker Adventist Hospital Emergency Care, or Rocky Mountain Hospital for Children. These hospitals are open 24 hours a day providing emergency care.

Denver/Boulder service area
Kaiser Permanente's Denver/Boulder service area serves Boulder, Broomfield, Denver, and Gilpin counties, and portions of Adams, Arapahoe, Clear Creek, Douglas, Elbert, Jefferson, Larimer, Park, Teller, and Weld counties.

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESS

A. **Summary:** Kaiser Permanente has established standards for both physician-to-member ratios and geographic accessibility. These standards are established and monitored according to medical specialty. Kaiser Permanente quarterly undertakes "geographic mapping" to assure that both the number of physicians and their geographic availability are within established standards. Network adequacy access for Kaiser Permanente's membership is determined by their driving distance to the nearest primary care, specialty care, and facility providers. Geographic membership trends and internal and external market analysis allow Kaiser Permanente to adjust the number of physicians and locations in order to accommodate the needs of its members.

- **Primary Care Provider (PCP)**:
  Kaiser Permanente will utilize heat maps to visually represent where our members reside and which providers they are bonded to in proximity to our provider locations. Kaiser Permanente will address those primary care provider categories not meeting the access standards through relocating some of our current providers, hiring new providers as needed, and/or contracting with additional network providers. Kaiser Permanente has also instituted a real-time, video-based telemedicine service for our members. Where appropriate, telemedicine will be available to provide additional access to care services for our members. For accessibility purposes Kaiser Permanente achieves a provider to enrollee ratio of 1:1000 for its membership in the Denver Boulder service area.

- **Specialists:** In the Denver Boulder market, Kaiser Permanente provides specialty care services at almost all 22 medical office locations and also contracts with certain specialty care providers including University Physicians, Inc. and other externally contracted partners to provide specialty care services. The mix of this contracted and integrated delivery model network ensures that all members in this service area are within the driving distance standard of certain specialty care services.

- **Obstetricians, Gynecologists, OB/GYN:** Kaiser Permanente utilizes its integrated delivery system to provide OB/GYN care for its membership. For accessibility purposes, Kaiser Permanente achieves a provider to enrollee ratio of 1:1000 for its female membership aged >13 in the Denver Boulder service area.

- **Pediatricians:** Kaiser Permanente offers pediatrics services through its medical office locations. Kaiser Permanente also ensures that its Primary Care Provider population has capacity to treat Pediatric membership. Kaiser Permanente achieves a 1:1000 provider to enrollee ratio ensuring accessibility for its Pediatric membership as well as ensuring that Pediatric membership (aged <19) are within certain geographic distance standards.

- **Behavioral Health Providers:** In the Denver Boulder network, members are able to be seen for routine behavioral health treatment at five Kaiser Permanente behavioral health offices. They also have access to an extensive network of contracted behavioral health facilities and providers in the Denver metropolitan area. Based on medical necessity criteria, a pre-authorization from KP Behavioral Health can be obtained if clinically indicated. The external contracted network can provide routine, urgent, and emergent behavioral health care services.

- **Pharmacy Providers**
  For its Denver Boulder network, Kaiser Permanente currently meets the standards for those members living within the geographic boundaries of the Denver Boulder service area. Kaiser Permanente will continue to evaluate the pharmacy needs of its membership and the current available pharmacy network. Kaiser Permanente's mail order pharmacy is available to provide additional access to care services for our members.

- **Acute Care Hospital Services:** Kaiser Permanente ensures that all members living within the boundaries of its geographic service area are within the driving distance requirement of acute care hospitals.

- **Emergency:** Emergency Care services can be accessed through the contracted hospital locations in the Denver Boulder network as well as several in-network freestanding emergency care centers in the Denver metropolitan area.

- **Urgent Care Facilities:** Kaiser Permanente offers urgent care services for its membership at its medical office building locations in the Lakewood, Aurora Centrepoint, and Lone Tree as well as several contracted in-network urgent care locations ensuring members are able to receive urgent care access within 24 hours.

- **Behavioral Health Facilities:** In the Denver Boulder service area there are five medical office locations that offer routine and urgent behavioral health care services. Additionally, Behavioral Medicine Specialists (BMS) are available in all Denver Boulder medical office buildings that offer primary care services. Kaiser Permanente meets the accessibility and geographic access for emergency behavioral health care services through contracted in-network providers that offer emergent and inpatient psychiatric care services. Kaiser Permanente meets the geographic access standards for inpatient psychiatric care in the Denver Boulder service area.

- **Providers Who May Be Available Through the Use of Telehealth**
  All CPMG physicians in primary care and all specialties who provide scheduled outpatient care have been trained and equipped to provide care by video. Kaiser Permanente CO has documented how the use of telemedicine or telehealth or other technology may be used to meet member care needs.

- **Other Provider and Facility Types**
  Kaiser Permanente works to maintain adequate networks for all of its provider and facility types. The Denver Boulder service area currently provides a sufficient number of providers and facilities as well as sufficient geographic access (driving distance from member's home address).

  Corrective Action Planning for Chemical Dependency: Though Kaiser Permanente of Colorado currently meets the adequacy threshold for driving distance standards and access standards to Chemical Dependency services, Kaiser Permanente is currently engaged in multiple interventions to improve accessibility for patient access to waiting time standards for mental health services including:
    - Complete staffing analysis to assess true demand and present FTE request by 7/31/19
    - Partner with local analytics to review current access reporting to ensure accuracy by end of Q3.
    - Fill any open therapist positions by 10/1/19
    - Fully optimize utilization of available overflow provider referrals
    - Offer telemedicine by 6/30/19 to assist in decreasing no show for appointments which results in lost access requirements are met

B. Monitoring the Sufficiency of Network

KPCO utilizes a documented process for measuring the sufficiency of our network to meet the healthcare needs of our enrollees. We use member-to-practitioner ratios and geographic access measurements. In addition, Kaiser Permanente of Colorado conducts ongoing network adequacy monitoring and meetings with those leadership teams accountable (e.g. Provider Contracting, Clinical Operations, etc…) for its network composition to ensure that current and potential membership population will have adequate access to certain provider and facility types as stated in DOI regulation 4-2-53.

Our contracts with providers require providers to notify us of any adds/changes/deletions to their provider profile as they occur. We also identify the expectations we have for reasonable accessibility and we have a communication process with the providers to ensure that any changes in availability or composition of their practices are documented. Kaiser Permanente performs a quarterly outreach to its entire provider network in order for them to attest to the accuracy of their provider group profile that is on record in the provider database that feeds to the online directory, kp.org. Our enrollees have online or telephonic tools to communicate any concerns they may experience in obtaining necessary health care services. At any time in any specialty where appropriate access is questioned, we will research the concern and remediate, if appropriate, to address the concern.

C. Factors Used to Build the Provider Network

Kaiser Permanente considers the following factors/criteria as it builds and maintains provider networks:

- Size and demographics of the population to be served;
- The inventory of provider types required to serve the population and using practitioner to member ratios and geographic access standards metrics to ensure adequacy;
- Application of rigorous credentialing criteria encompassing but not limited to educational training, licensing, professional experience, board certification, and professional references.

Kaiser Permanente uses the same quality, member experience, or cost-related measures to select practitioners and facilities in Marketplace Silver-tier plans as it does for all other Kaiser Foundation Health Plan (KFHP) products and lines of business. Members enrolled in KFHP Marketplace plans have access to all professional, institutional and ancillary health care providers who participate in KFHP plans' contracted provider network, in accordance with the terms of the members' KFHP plan of coverage. All Kaiser Permanente Medical Group physicians and network physicians are subject to the same quality review processes and certifications.

D. Quality Assurance

Kaiser Permanente Colorado (KPCO) is Colorado's largest nonprofit integrated health care delivery system, operated by Kaiser Foundation Health Plan (KFHP) of Colorado and the Colorado Permanente Medical Group (CPMG). Together, the two entities have provided comprehensive health services to Kaiser Permanente members in Colorado for 49 years. We will celebrate our 50-year Anniversary on July 1, 2019. Per Kaiser Foundation Health Plan of Colorado Human Resources, the health plan has employed 6,700 staff as of January 2019. Colorado Permanente Medical Group employs 1200+ physicians representing Primary Care, Behavioral Health, Pediatrics, Obstetrics/Gynecology and numerous medical and surgical specialties, and 135 professional staff (non-physicians). Kaiser Permanente provides care for approximately 650,000 members in Denver, Boulder, Southern Colorado, and Northern Colorado.

Quality and Health Improvement Committee (QHIC)

The Board of Directors oversees quality through the national Quality and Health Improvement Committee (QHIC). The QHIC consists of three or more Directors, who are selected by the Board and who serve as members of the QHIC at the pleasure of the Board. The QHIC meets at least four times per year and reports its decisions, actions, and recommendations to the Board. Staff support is provided by the National Health Plan and Hospitals Quality Department. The Quality and Health Improvement Committee (QHIC) provides:

- Strategic direction for quality assurance and improvement systems.
- Oversight of systems designed to ensure that quality care and services are provided at a comparable level to all members and patients throughout the Program and across the continuum of care.
- Oversight of the Program's quality assurance, improvement systems and organizational accreditation and credentialing.

Kaiser Permanente National Quality Committee (KPNQC)

The mission of the Kaiser Permanente National Quality Committee (KPNQC) is to establish, guide, and support the National Clinical Quality Strategy, which will set uniform measures and targets, eliminate unwarranted variation, spread successful practices, and facilitate the delivery of safe, timely, effective, equitable, efficient and patient-centered clinical care by the Kaiser Permanente Medical Care Program, in furtherance of the Quality Programs, developed collaboratively with Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and the Permanente Medical Groups.

KPNQC is accountable to and acts at the direction of QHIC. As part of its oversight responsibilities, KPNQC reviews annual program descriptions, work plans and evaluations, as well as quality reports and minutes from each region. KPNQC meets no fewer than four (4) times per year and is a peer review body.

The Regional SQRMC is charged with developing, implementing and overseeing Quality, Resource Stewardship, Service Improvement activity and Patient Safety in the Colorado region.

E&F. Corrective Action Plans for Deficiencies Identified in Network Adequacy Monitoring

If, as a result, of Kaiser Permanente's ongoing network adequacy monitoring a deficiency or gap in network adequacy is found for members in a service area, the organization will work with the clinical operations teams and the Colorado Permanente Medical Group leadership teams to determine whether the deficiency can be filled with the integrated delivery model by providing additional staffing at a Kaiser Medical Office location. If the addition of a provider through the integrated delivery model of Kaiser Permanente is not feasible, leadership from the Provider Contracting teams will be notified to identify if the gap can be closed thought a network provider. The network provider that is identified to close the network adequacy gap will be expected to meet a set of standards to provide capacity to its membership as would be expected in the integrated delivery model. The credentialing period and insurance of sufficient healthcare delivery to its member population is a process that can take from three to six months.

If no such provider exists that can fill the gap, Kaiser Permanente will employ remote health methodology including but not limited to the use of telehealth medicine and mail order pharmacy to provide sufficient medical care needs to its membership population. Such deficiencies will be reported to the DOI in the annual binder filing if no remedy can be employed to close the network adequacy gap.

G. Obtaining Covered Benefits from Non-Participating Provider if Network is Not Sufficient

Refer to "Procedures for Referrals" section of this Access Plan.

Kaiser Permanente provides services to our members using Colorado Permanente Medical Group (CPMG) physicians and network providers. If there are services that are not available within CPMG or the network, Kaiser Permanente will provide authorizations to qualified external providers for the service that is not available. Kaiser Permanente will utilize local providers when possible, or out-of-state specialists, if necessary.

H. Process for Monitoring Access to Physician Specialist Services

Kaiser Permanente has processes for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at our contracted hospitals.

Refer further to process outlined in "Monitoring the Sufficiency of Network" section.

3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

A. Comprehensive Listing of Providers and Facilities

Kaiser Permanente's Provider Directory is available on kp.org and from Member Services and includes all of our contracted providers and facilities.

B. Procedures for Referrals

Members may self-refer to a CPMG specialist in the OB/GYN, eye care and behavioral health departments, including chemical dependency treatment services. A referral from a primary care physician is not required for these specialty departments. Members may also self-refer to most specialty care providers for a routine consultation visit without the need for a referral from their PCP. Specialty self-referral is in addition to, not a replacement for, referrals from primary care physicians to specialty care providers.

Referral Options

In-plan Specialty Referrals: CPMG physicians determine when specialty care is necessary. Pre-authorization from the Health Plan is not required for a referral to a CPMG specialist. Decisions about specialty referrals often occur through PCP/Specialist consultation. The referral process includes the following:

- The primary care physician enters the referral to the specialty department in the electronic medical record.
- The member contacts the specialist's department directly to make an appointment.
- Only one referral is needed even if multiple visits are required.
- If an appropriate specialist is located at the primary care physician's medical office, the member will be referred to that individual. However, members may choose to see any CPMG specialist who is appropriately qualified to provide the referral services.

Referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services.

Timely Referrals for Access to Specialty Care
Kaiser Permanente processes all referrals according to applicable State/Federal and NCQA timeline requirements. Kaiser Permanente's "Timeliness of UM Decision Making Policy and Procedure" addresses the process for referral timeliness requirements.

Utilization management decisions and notifications to covered person (members/participants/beneficiaries) and practitioner/providers are made as expeditiously as the covered person's health condition requires and in a timely manner that accommodates the clinical urgency of the situation, regulatory requirements, and/or NCQA standards. Generally, the standard with the strictest requirement is utilized in the UM process. A request may be initiated (orally or written) by the Covered person, by a provider acting on behalf of the covered person or covered person's authorized representative. All oral requests will be documented and maintained in writing.

Expedited Referral Process
Kaiser Permanente has a process for expediting the referral process. Kaiser Permanente's "Timeliness of UM Decision Making Policy and Procedure" addresses the process for urgent referrals.

Approved Referrals Cannot be Retrospectively Denied
Referrals approved cannot be retrospectively denied, except for fraud, abuse and changes in eligibility.

Approved Referrals Cannot be Changed After Preauthorization
Referrals cannot be changed after preauthorization.

Disclosure of Variable Deductible, Coinsurance and/or Copayments
Kaiser Permanente does not offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers.

C. Process for Allowing Members to Access Services Outside the Network When Necessary - Out-of-plan Referrals

Kaiser Permanente contracts with community providers, called affiliated providers, to provide services not available from CPMG. CPMG physicians provide an electronic authorization request to KFHP when referring members to affiliate providers. Referrals outside of CPMG generally occur when a specialist of appropriate expertise is not available within CPMG.

Kaiser Permanente's Central Referral Center staff, registered nurses, or other licensed staff facilitate the review of the physician's request for an out-of-plan referral, verifying that the member is currently enrolled and is covered for the referred service.

Only a Kaiser Permanente Utilization Management (UM) Physician Reviewer can deny a service for medical necessity (not clinically indicated). Other denials may be based on benefits. These are determined and processed by Resource Stewardship staff, registered nurses, or other licensed staff.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

A. Method for Informing Covered Persons

Kaiser Permanente annually provides members with a Membership Agreement or Evidence of Coverage (EOC) summarizing the benefits and services available to each member. Coverage varies depending on the particular plan in which the member is enrolled. Members may view a copy of their Membership Agreement or EOC as a registered member at **kp.org.** Members may obtain a printed copy of the Membership Agreement or Evidence of Coverage by calling Member Services, toll-free **1-888-681-7878**, weekdays, from 8 a.m. to 5 p.m. Deaf or hard of hearing people who use TTY may call **711**. The Membership Agreement or EOC includes information on the following:

- **Grievance Procedures**

  Information on Kaiser Permanente's appeals and complaints procedures and filing claims that is in conformance with the Division rules.

- **Availability of Specialty Medical Services**

  Information about the availability of specialty services, including behavioral health, physical therapy, occupational therapy and rehabilitative services**.**

- **Procedures for Providing and Approving Emergency and Non-Emergency Medical Care**

- **Process for Choosing and Changing Network Providers**

- **Covered Persons with Limited English Proficiency and Illiteracy**

Access to Services for Foreign Language Speakers

- Member Services will provide a telephone interpreter to assist members who speak limited or no English.
- Plan physicians have telephone access to interpreters in over 150 languages.
- Plan physicians can also request an onsite interpreter for an appointment, procedure or service.
- Any interpreter assistance we arrange or provide will be at no charge to the member.

ReadSpeaker (text-to-speech) converts online text to speech and highlights text as it is being read. ReadSpeaker is available on Kaiser Permanente.org. TTY numbers are also published in all member materials.

Assessing Health Care Needs and Evaluating Member Satisfaction

Kp.org website includes information on the following:

- Kaiser Permanente in partnership with Johnson & Johnson Health and Wellness Solutions offers a health risk-assessment branded as the Total Health Assessment (THA) as well as eight (8) Healthy Lifestyle Programs (HLPs) to all members registered on kp.org. The THA and HLPs are evidence-based behavior change programs. The programs engage participants in understanding their health status and support behavior change. The total health assessment (THA) is Kaiser Permanente's health risk appraisal tool. Kaiser Permanente members complete a detailed online questionnaire to assess demographics, health goals, interests, motivations, and barriers to healthy living. To access the THA, members visit Kaiser Permanente's website at **kp.org/healthylifestyles**. Based on the responses, participant receive a customized action plan, follow-up newsletters designed specifically for their needs, as well as an evaluation regarding behavior change, confidence, and other areas related to health outcomes.

  The following are some features of the THA program:

  - Members complete an online questionnaire that asks members about their health risks and medical history. The questionnaire includes questions about diet, driving habits (seatbelt use), exercise habits, and other habits and behaviors that affect health.
  - Based on answers to the questionnaire, members receive a personalized report that summarizes their health risks along with information to help with behavior change.
  - The responses are strictly confidential and cannot be released without the member's specific authorization. Members' answers will not affect their health benefits from Kaiser Permanente in any way.

The THA is designed to educate and motivate members to improve their health and helps members and their physicians target specific programs that help meet the individual's health needs.

Kaiser Permanente's website also offers members access to interactive online health tools and calculators to help members manage their weight, lower stress, quit smoking and become more fit. In addition, **kp.org** enables members to look up information on drugs or medical conditions, request or reorder health ID cards, check the facility or medical staff directory and view, print and/or download the *Member Resource Guide*, a reference guide to Kaiser Permanente services.

In addition to the THA, Kaiser Permanente has developed a state-of-the-art health maintenance appointment, based on recommendations from the U.S. Preventive Services Task Force, the American Heart Association, the American Cancer Society, the American College of Obstetrics and Gynecology and the American Medical Association. Kaiser Permanente health maintenance appointments are:

- Age-specific.
- Emphasize member's individual health history and personal habits.
- Include tests and procedures for those at risk for developing a disease due to personal habits or family history.

Member Satisfaction

Kaiser Permanente uses several methods to inquire of members how satisfied they are with the services received. On an ongoing basis, information is gathered from satisfaction surveys, including the Member Experience Tracking Evaluation and Opinion Research Survey (METEOR), Patient Satisfaction Survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Art of Medicine, reviews posted publicly on the web, and the review and evaluation of complaints and appeals.

Survey feedback is collected through three methods dependent on the survey. CAHPS and METOER surveys are the most robust using mail, phone and web-based surveys. The Patient Survey and the Art of Medicine primarily use web with phone outreach to supplement areas where KPCO does not have an email address for the member or to follow-up with those members who have not responded to the email invitation.

Both the CAHPS and METEOR Surveys assess the members' experiences with both health care received, customer service within the health plan and information about plan and benefits. The Patient and Art of Medicine surveys follow a specific visit and focuses on member's satisfaction with their visit including appointment access satisfaction and scheduling; physician's manner, attitude; overall visit satisfaction; and coordination of care. Physicians take these evaluations very seriously. If the rating is poor, the physician is counseled and goals are set for improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
CAHPS is required by NCQA (National Committee for Quality Assurance), and is used for accreditation purposes as well as ranking participating health plans nationally. Results are intended to help guide consumers and purchasers in their selection of a health plan; and also to provide internal feedback around service/process improvements (e.g., members report experiences within the past 12 months). The CAHPS Survey is a random survey of members regardless of visit experience and is fielded in the spring each year with reports distributed by the end of the summer.

Member Experience Tracking Evaluation and Opinion Research (METEOR)
The METEOR survey is a combination of the CAHPS survey with supplemental

(METEOR) questions. Results are intended to provide additional insight and larger sample for tracking various CAHPS metrics. Interviews are conducted among a random sample of members fielded in the fall with reports distributed by the end of the year.

Diversity and Inclusion Center of Expertise Program

Overview
KPCO is committed to the Equity, Inclusion and Diversity Strategy and acknowledges that it is a key business strategy essential to maintaining high-quality, best service, affordable health care and making KPCO the best place to work. The program is guided by the National Office of Equity, Inclusion and Diversity, which serves as a national policy advisor to leadership and a sponsor of strategic initiatives to advance the Equity, Inclusion, and Diversity.

Purpose and Goals
The mission of the KPCO EID work is to develop a climate focused on the elimination of health disparities of members and their communities by integrating equity, inclusion and diversity into all aspects of the organization by ensuring a diverse and culturally competent workforce. As part of this mission, the KPCO assesses cultural and linguistic needs and preferences of the member population and compares these against the current workforce and regional demographics.
The KPCO EID strategy will focus on the following objectives to achieve the above mission:

- Share relevant Affirmative Action Plan (AAP) goals or hiring opportunity areas with Regional Execs & Sr. Dir's. (implementation by regional HR & EID).
- Implement a standardized diverse panel of interviewers for each opportunity area. (guidance from National TA Strategy).
- Standardize interview process (i.e. structured interview questions and scoring of each candidate) (guidance from National TA Strategy).
- Train managers to execute talent calibration process - minimizing bias.
- Encourage CO managers to partake in the Inclusive Climate Learning Solutions (in partnership with NEID and Regional HR and regional EID).
- Integrate EID Course into New Hire Orientation experience (implementation by Regional HR & EID).
- Support newly promoted/hired people-managers within the CO region with unconscious bias training (implementation by Regional HR & EID).

Structure and Approach
KPCO is a complex organization that requires a coordination of diversity roles, relationships and resources to ensure efficiency, cost-effectiveness and comprehensiveness. In addition, our organization creates and maintains adequate access to our practitioners and facilitates linking our members with practitioners who can meet the member's diverse cultural, racial, ethnic and linguistic preferences in the KPCO service areas.

KPCO Equity, Inclusion, and Diversity works through partnerships with CPMG, KFHP Leadership and Labor regarding workforce diversity and clinical aspects of the program to

ensure delivery of culturally competent care, and the quality and service departments to determine health care gaps or HEDIS and Equitable Care Health Outcomes (ECHO) measures to identify disparities.

Kaiser Foundation Health Plan (KFHP)
Workforce diversity is another important aspect of the KPCO Equity, Inclusion, and Diversity strategy. KPCO understands that the population of Colorado is diverse and has differing needs and expectations surrounding health care and customer service, based on individual background and culture. KPCO aggressively recruits to assure that our workforce meets the cultural, ethnic and linguistic needs of our members. This is a joint effort between the Recruitment Staff and KPCO HR BPs to reach out to diverse populations by actively networking, advertising, attending and participating in various culturally diverse career fairs and events. The Human Resource Business Partners (HR BPs) work with Hiring Managers to educate and meet their AA goals. The HR BPs act as the point of contact for leaders across the organization and HR.

National Diversity Council
The council is attended by national and regional diversity leadership and is responsible for implementation oversight of the National Diversity Agenda (objectives). It also serves as policy advisor to the CEO of KFHP/KFH, National Executive Team, and the Executive Director of the Permanente Federation and Kaiser Permanente Program Group (KPPG). It develops the Strategic Plan for Diversity and Inclusion used in implementation of the National Diversity Agenda (objectives) and provides strategic direction for diversity through development of national policy and initiative proposals. In addition, the National Diversity Council: (1) serves as diversity policy advisors for the Program; (2) consults and advises the Program Office and regional leadership on the strategic direction of diversity in the Program; (3) assists regions to assure progress toward achieving key diversity objectives; (4) serves as consultants and advisors to regional executive leadership and Regional Diversity Councils in implementation of the National Diversity Agenda; (5) advances integration of diversity into the organization's core business infrastructure; (6) leads development and implementation of the Strategic Plan for Diversity; and (7) expands the diversity infrastructure as appropriate to effectively implement key national diversity initiatives.

Data Collection and Analysis
Collection of demographic data is mandated by state and federal policy and occurs at multiple areas throughout the organization. At Kaiser Permanente–owned facilities, information about members' race, ethnicity and language preference (RELP) is collected during a medical appointment using a member survey tool. Nursing staff are trained to administer the member survey during the rooming process and to enter the information directly into Health Connect, Kaiser Permanente's electronic medical record.

Clinical data is collected to report HEDIS measures to the NCQA. The data is analyzed quarterly at the national level, based on selected HEDIS measures to identify trends in disparities and opportunities for improvement.

5. PLAN FOR COORDINATION AND CONTINUITY OF CARE

A& B. Coordination and Continuity of Care for Specialty and Ancillary Services

Kaiser Permanente has documented processes for ensuring the coordination and continuity of care for covered persons in our Transition of Care, Member Notification and Continued Access Process Policy.

Care managers evaluate patient health status and collaborate with the PCPs/specialists to develop a plan of care management for the members. All care managers promote patient self-care, evaluate and support caregivers' informational needs, and educate members/care givers on ancillary services, including social services and other community resources.

C. Process for Ensuring Appropriate Discharge Planning

Members are informed about care alternatives during hospitalization as part of the hospital discharge planning process.

Kaiser Permanente monitors all discharges by partnering with hospital staff to risk score all members with LACE score (LACE score is a validated tool supported by literature which predicts likelihood of readmission and is scored across these four elements: Length of stay, Acuity, Comorbidities, ED visits in last 6 months). At-risk members receive care from a Care Management Team, CMT (RN, Clinical Pharmacist) post discharge.

Transition bundle includes: post discharge phone call, medication reconciliation, symptom/disease management education, ensure that member has appropriate follow-up appointment based on individual care plan, and appropriate DME is in place (oxygen, specialized bed etc). The care from the CMT is provided to patients bonded to a CPMG provider.

D. Process for Covered Persons to Change Primary Care Professionals

Information about Kaiser Permanente's process for enabling covered persons to change primary care professionals is detailed in the Membership Agreement or EOC, and as copied below:

Choosing Your Primary Care Provider
You may select a PCP from family medicine, pediatrics, or internal medicine within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request.

You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

Colorado Permanente Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the Southern

and Northern Colorado Service Areas. You may choose your PCP from our panel of Southern and Northern Colorado providers.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your home Service Area. You can review a list of Southern and Northern Colorado Plan Providers by visiting our website. Go to kp.org/locations. You can also get a copy of the directory by calling Member Services. To choose a PCP, call Personal Physician Selection Services. This team will help you choose a primary care provider that is accepting new patients based on your health care needs.

If you are seeking routine or specialty care in Denver/Boulder, you must have a referral from your local PCP with an Authorization from Health Plan. If you do not have an Authorization, you will be billed for the full amount of the office visit charges. If you are visiting in the Denver/Boulder service area and need urgent or emergency care, you can visit a Denver/Boulder Plan Facility without a referral. For a referral from a specialist, see the "Access to Other Providers" section. For care in Denver/Boulder Plan Medical Offices, see "Cross Market Access," below.

Changing Your Primary Care Provider
Please call Personal Physician Selection Services to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

E. Process for Providing Continuity of Care in the Event of a Contract Termination

In the event that Kaiser Permanente discontinues service in any region, arrangements will be made, in compliance with state and federal requirements, to transfer operations to another organization with no disruption in services. Members will be advised of this action well in advance. Kaiser Permanente makes a good faith effort to provide timely written notification to health plan members affected by the termination of a practitioner or practice site. Members who are affected by changes in the practice of a PCP, specialty care practitioner or practice site resulting from resignation, retirement, increased administrative responsibilities or transfer to another medical facility/office **are mailed a written letter within 15 to 30** days of the **practitioner's formal notification** to the Health Plan/Medical Group of termination of employment/practice. In addition, Kaiser Permanente has established a process with its terminating primary care providers to ensure that this formal notification will be sent to all bonded members.

Under certain conditions, Kaiser Permanente members may be given the option to continue seeing the terminating practitioner if the terminating practitioner agrees to all "Continued Access" criteria and determines that the member qualifies for continued care. Members are informed of this continued access option in a written notification.

F. Hold Harmless Contract Provisions

Kaiser Permanente has the following "hold harmless" provision in our provider contracts, prohibiting contracted providers from balance-billing enrollees in the event of the issuer's insolvency or other inability to continue operations in compliance with Section 10-16-705(3), C.R.S.

Member Hold Harmless. Except as expressly provided in Section 3.4 (Billing Members), Provider (and any Subcontractors) shall look solely to the responsible Payor for compensation for Covered Services rendered to Members, and Provider agrees that in no event (Including non-payment by Payor, insolvency of Payor or breach of this Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, State or any Medicaid plans, for Covered Services provided under this Agreement. Without limiting the foregoing, Provider shall not seek payment from Members for amounts denied by Payor because (i) billed charges were not customary or reasonable, (ii) the Services were not medically necessary, (iii) the Services were not Authorized, or (iv) Provider failed to submit claims within the appropriate time frame or in accordance with the Provider Manual.

Regulatory Appendix: Hold Harmless. [3 CCR 702-4, Amended Regulation 4-7-1] Provider agrees that the provisions of Section 3.3 of the Agreement, Member Hold Harmless, shall survive the termination of this Agreement for Authorized Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members. This provision is not intended to apply to services provided after this Agreement has been terminated. Provider further agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the Provider and the Member or persons acting on his/her behalf insofar as such contrary agreement relates to liability for payment of Services provided under the terms and conditions of this Agreement. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner of Insurance has received written notification of proposed changes.