KAISER FOUNDATION HEALTH PLAN OF COLORADO

2025 Access Plan

Select Colorado Network (KPIF and Small Group)

Contents

1. INTRODUCTION

Carrier Name: Kaiser Foundation Health Plan (KFHP) of Colorado
Full Name of Network: Kaiser Permanente Select Colorado for KPIF and Small Group
Carrier Network ID Number: CON002 & CON004

Kaiser Foundation Health Plan (KFHP) of Colorado is the largest nonprofit health plan in the state. It is part of an integrated health care delivery network, Kaiser Permanente, that includes Kaiser Foundation Health Plan (KFHP) of Colorado and the Colorado Permanente Medical Group (CPMG). Kaiser Permanente provides comprehensive health care services to its members through CPMG physicians and a network of physicians and other providers that contract directly with CPMG and KFHP of Colorado.

The Kaiser Permanente website, **kp.org**, provides a list of plan providers, their locations, and their specialties. Members may also request a list of providers and facilities by calling Member Services at 303-338-3800 or 1-800-632-9700 (TTY 711), Monday through Friday, from 8 a.m. to 6 p.m.

Members should refer to their Evidence of Coverage or Membership Agreement for details on providers in-network and out-of-network for their particular plan. Members are able to access CPMG primary and specialty care services at Kaiser Permanente Medical Offices. Members may make appointments at **kp.org** or by calling the Clinical Contact Center at 303-338-4545 or 1-800-281-1059 (TTY 711), Monday through Friday, from 6 a.m. to 7 p.m. Members may call that same number for medical advice. Members may also find affiliated network providers in the provider directory at **kp.org**. Kaiser Permanente also has contracted urgent and emergency care locations across Colorado. Members may find a list of urgent and emergency care locations at **kp.org**.
Kaiser Permanente also has contracted urgent or emergency care locations across the service area. Members can also find a list of urgent and emergency care locations at **kp.org.**

KP Select service area
The KP Select product is only available in the Colorado Springs and Denver Boulder metro areas. Members must reside in the counties of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Park, and Teller counties.

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESSES

A. Summary

Kaiser Permanente has standards for provider-to-member ratios, geographic accessibility, and appointment wait times that comply with Colorado Division of Insurance (DOI) regulation. Kaiser Permanente quarterly undertakes “geoaccess” reporting to assure that both the number of physicians and their geographic availability are within established standards. Network adequacy geographic accessibility 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.

Kaiser Permanente meets geographic access, provider-to-enrollee ratio, and appointment wait time requirements as described below:

Appointment Wait Time Standards:
Kaiser Permanente meets Appointment Wait Time standards for Emergency Care, Urgent Care, and many areas of non-urgent Specialty Care.

Kaiser Permanente is not meeting the prescribed appointment wait times for:

- Initial and follow-up routine, non-urgent Behavioral Health/Mental Health/SUD care
- routine, non-urgent Primary Care
- preventive visits for colonoscopy and mammography
- non-urgent specialty care

Please see the Corrective Action Process section for more information on how KP is working to improve access in these areas.

Provider-to-Enrollee Ratios:
Kaiser Permanente meets all Provider-to-Enrollee Ratio requirements.

Geographic Access Standards:
Kaiser Permanente meets all Geographic Access standards except for those listed below. Please see the Corrective Action Process section for more information on how KP is working to improve access in these areas.

Denver County	Douglas County	El Paso County
Gynecology, OB/GYN	Gynecology, OB/GYN	Gynecology, OB/GYN
Podiatry		

Kaiser Foundation Health Plan of Colorado has contracted with the Colorado Permanente Medical Group as well as numerous affiliate providers in the community to ensure that members have access to all services as appropriate.

B. Monitoring the Sufficiency of the Network

KFHP utilizes a documented process for measuring the sufficiency of our network to meet the healthcare needs of our enrollees. As part of this process, Kaiser Permanente conducts ongoing network adequacy monitoring to ensure that current and potential membership population will have adequate access to provider and facility types (including Hospitals and all hospital services), as stated in DOI regulation.

Our contracts with providers require them to notify us of any adds/changes/deletions to their provider roster as they occur. We also identify the expectations we have for reasonable accessibility, and we have a communication process with our 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.

Telehealth Services:
All CPMG physicians in primary care and all specialties who provide scheduled outpatient care are able to provide medically appropriate care by video. Many of our contracted network providers are also able to provide care virtually when medically appropriate. Kaiser Permanente has documented how the use of telemedicine, telehealth, or other technology may be used to meet member care needs, but telehealth providers are not included in the network adequacy analysis.

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.

The Select network features a mixture of CPMG physicians and community providers that deliver primary care and specialty care. Prevalence of community providers depends on service area needs and what is required in order to meet geographic accessibility requirements for its membership. The Colorado network is supplemented with a high volume of contracted providers in the Northern and Southern parts of the region.

Provider Tiering
The KP Select network doesn’t utilize any provider tiering that would result in variable copayments, coinsurance, or deductibles.

D. Quality Assurance

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.

Kaiser Permanente Colorado Quality Oversight Committee (QOC)
The Quality Oversight Committee (QOC) supports Kaiser Permanente by providing oversight and evaluation of the effectiveness of all aspects of the Quality Program, including clinical quality, access to services, service quality, and safety. It is co-chaired by Kaiser Foundation Health Plan of Colorado's Vice President, Quality Safety, and Research and by Colorado Permanente Medical Group's Vice President and Chief Quality Officer. Membership includes physicians and health plan clinical and quality leaders. The QOC reports its activities and functions to the KFHP Board of Directors through QHIC.

The purpose of the QOC is to:

- Recommend quality strategies in alignment with National and Regional strategic priorities, mission, and vision.
- Oversee and evaluate quality assessment and improvement activities throughout the Region.
- Be accountable to the KFHP Quality Health Improvement Committee (QHIC) for safety and quality of clinical care and services.

QOC Subcommittees
The QOC assigns certain responsibilities to subcommittees that are required to report to QOC at least three times a year, or more often if necessary. The charters for each subcommittee are updated annually and include expectations, authority/scope, and membership. QOC membership and subcommittee membership is reviewed annually. The subcommittees of the QOC are:

- Behavioral Health Quality Oversight Committee (BHOC)
- Continuum of Care Quality Oversight Committee (CCOC)
- Credentialing/Privileging Committee (CPC)
- Government Programs Quality Oversight Committee (GPOC)
- Integrated Safety Quality Oversight Committee (ISOC)
- Quality Metric Oversight Committee (QMOC)
- Regional Services Quality Oversight Committee (RSOC)

E. Corrective Action Process

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 through contracting with 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. An extensive credentialing process occurs to ensure quality healthcare delivery to the member population.

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.

F. Access Improvement Plans

Appointment Wait Time Issues:

In order to improve appointment access to initial and follow-up behavioral health, mental health, and substance use disorder care, KP has been working to improve access through:

- Increased hiring
- Adding Behavioral Health Consultants in Northern and Southern Colorado Primary Care Medical Office Buildings
- Additional contract with one to two large external provider vendor groups

In order to improve access to Primary Care appointments, KFHP has:

- Continuing to add incentive shifts to increase supplied appointments
- Increased the number of patients our Primary Care Physicians see each day – panel size has also been adjusted to allow providers to take on more patients

In order to improve access to non-urgent specialty care and preventive/well visits, KFHP is working to hire and contract with additional providers in the affected specialties.

Geographic Access Issues:

The KP Select network is currently experiencing numerous geographic access issues; KFHP is looking into the best way to fill each of these gaps, either through the redistribution of providers in our Medical Office Buildings or, if that is not sufficient, contracting with additional providers in the affected areas, by the end of 2024. Many of these gaps are minimal and do not represent a significant lack in access; regardless, KFHP is seeking to add to the network to close these gaps.

Kaiser Permanente allows members to seek care from out of network providers at in-network rates if they are affected by one of the network inadequacies listed above. See section 2G “Obtaining Covered Benefits if Network is Not Sufficient” for more information.

G. Obtaining Covered Benefits 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 and coverage at the in-network benefit level 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.

Kaiser Permanente's policy is to review of out-of-network authorization requests and to establish single case rate agreements for providers outside of the network, that the cost shall not exceed the cost of the same and or equal service to providers in-network.

H. 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 the process outlined in "Monitoring the Sufficiency of Network" section.

3. 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 network providers and facilities. The online directory is updated on a daily basis. The provider directory is also available in Spanish both online and in print.

B. Procedures for Referrals

1. **Referral Options** Referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services. Generally, you will need a referral and prior Authorization in order to receive services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization for some services in order to obtain access like Primary Care Provider (PCP) visits, eye care services, or OB/GYN care.
2. **Timely Referrals for Access to Specialty Care** Kaiser Permanente processes all referrals according to applicable State/Federal and NCQA timeline requirements and makes the determination as expeditiously as the member's health condition requires, but no later than 15 calendar days after the receipt of the request. A one-time, 15-day extension may be granted if requested or if it is justified. Kaiser Permanente's "Utilization Review Timeliness Policy and Procedure" addresses the full process for referral timeliness requirements.
3. **Expedited Referral Process** If a provider or member believes a request for medical/behavioral health/substance use disorder care or services where application of the time frame for making routine or non-life-threatening care determinations does do the follow:
    - Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement, OR
    - Seriously jeopardize the life, health or safety of the member or others due to the

member's psychological state, OR

- In the opinions of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. Then UM shall make the determination and notify the member or member's representative and the provider/medical facility of the determination, as soon as possible, taking into account the medical condition of the member, but no later than seventy-two (72) hours after the receipt of the request. Kaiser Permanente's "Utilization Review Timeliness Policy and Procedure" addresses the full process for referral timeliness requirements.

4. **Approved Referrals Cannot be Retrospectively Denied** Referrals that have been approved cannot be retrospectively denied, except for fraud or abuse.
5. **Approved Referrals Cannot be Changed After Preauthorization** Referrals cannot be changed after preauthorization unless there is evidence of an error, fraud, abuse, changes in eligibility, or a modification request submitted by the provider or member.
6. **Disclosure of Variable Deductible, Coinsurance and/or Copayments** Member cost-sharing, copayments, and deductibles can be found on the member ID card.

C. Out-of-plan Referrals

If your plan provider decides that you need covered services that are not available from Kaiser Permanente, they will request a referral for you to see an Out-of-Plan Provider.

4. DISCLOSURES AND NOTICES

A. Method for Informing Covered Persons

Kaiser Permanente annually provides members with an 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 EOC as a registered member at **kp.org/mydocuments**. Members may obtain a printed copy of the EOC by calling Member Services, **303-338-3800** or toll-free **1-800-632-9700**, weekdays, from 8 a.m. to 6 p.m. Deaf or hard of hearing people who use TTY may call **711**.

B. Required Disclosures:

The EOC includes the following information:

1. Grievance Procedures

   All members or their designee have the right to request an appeal of an adverse benefit determination. There are three distinct procedures for appeals that are determined by the type of claim(s) being appealed. Please refer to the EOC for more detail.

   When an appeal is filed, we will review the claim without regard to our previous adverse benefit determination. Appeals involving medical necessity determinations will be reviewed by a physician reviewer. After completing the first level of this internal review process, a member may request a Voluntary Second Level of appeal; or an additional review by an outside, independent reviewer if the denial is based on medical necessity, efficacy; investigational; or experimental as provided for by federal or state law.

   In situations involving an "urgent" medical condition, members may request an expedited appeal, and may in some situations request simultaneous expedited internal and external review.

2. Availability of Specialty Medical Services
   Information about the availability of specialty services, including behavioral health, physical therapy, occupational therapy, and rehabilitative services**.**
3. Providing and Approving Emergency and Non-Emergency Medical Care
4. Process for Choosing and Changing Network Providers
5. Process to address the needs of covered persons with Limited English Proficiency and Illiteracy

Non-Discrimination Notice:

6. Kaiser Permanente Colorado's 'nondiscrimination and help in your language' notice contains information on how a member can obtain language assistance services (including ASL) at no additional cost to the member. This notice is contained in essential documents. For example, it is included in the Open Enrollment Guide and the New Member Guide (which are sent upon enrollment) as well as other marketing materials such as the Provider Directory and member benefit packages. It is also posted on KP.org and in all Kaiser Permanente Colorado Medical Office Buildings. Kaiser Permanente Colorado also provides a TTY number alongside all phone numbers in all member marketing materials. The Equity, Inclusion, and Diversity program described below details KFHP's processes for identifying the needs of special populations and eliminating health disparities for our members and communities.

Equity, Inclusion and Diversity

- In order to identify the potential needs of special populations, KFHP has developed an Equity, Inclusion, and Diversity program, described below:

KFHP established the national diversity and inclusion function in 1997 to operationalize the company's diversity and inclusion strategy across the organization. In 2017 the name was changed to National Equity, Inclusion, and Diversity to reflect the increasing focus on equity for members, patients, employees, and communities. This department leads efforts to implement KP's equity, inclusion, and diversity strategy through the development of key initiatives and expert consultation throughout the enterprise.

In Colorado, the team responsible for implementing and guiding the EID Strategy reports to the Vice President of Human Resources. The EID Team includes the Director of Performance Improvement, Learning & Organizational Effectiveness, and EI&D, the two EID Consultant IV positions.

Equity, Inclusion and Diversity (EID) councils exist at both the national and regional levels. They are responsible for engaging employees in EID initiatives and programs and are accountable for achieving diversity-related goals.

Regional Overview

The mission of the regional Colorado EID team is to focus on the elimination of health disparities of members and their communities by integrating diversity, equity, and inclusion into all aspects of the organization by ensuring a diverse and culturally competent workforce. As part of this mission, Kaiser Permanente assesses the cultural and linguistic needs and preferences of the member population and compares these against the current workforce and regional demographics.

Consistent with its mission, Kaiser Permanente Colorado oversees a comprehensive diversity strategic plan, develop and endorsed by the National Office of Equity, Inclusion, and Diversity, focusing on integrating diversity and inclusion into all aspects of the organization. One main areas of focus is to create an environment where all staff and members feel valued and respected.

KP will focus on the following objectives to achieve the above mission:

- Train all staff and physicians to Break Bias and Dismantle Racism through Belong@KP
- Identify barriers in the delivery of health care to diverse populations.
- Identify our member's linguistic needs and cultural identity using member self-identification and compliance data.
- Prepare staff to provide ethnically, racially, culturally, and linguistically appropriate medical care and services to improve the health and satisfaction of our increasingly diverse membership.
- Enhance the diversity, cultural competence, skills, and performance of our workforce.
- Identify bilingual providers within each service area.
- Evaluate, track and document best practices, and share them with other KP regions.
- Support membership growth through ensuring we have a diverse workforce aligned with specific populations that are emerging segments of society; and,
- Focus on workforce equity in partnership with the National Office of Equity, Inclusion and Diversity (EID).

7. Assessing Health Care Needs and Evaluating Member Satisfaction

The kp.org website includes information on the following:

- Kaiser Permanente, in partnership with Rally Health, offers a health risk assessment branded as the Total Health Assessment (THA) and 9 Healthy Lifestyle Programs (HLPs) to all members registered on kp.org. The THA and HLPs are evidence-based behavior change programs that engage participants in understanding their health status and support behavior change. The THA is Kaiser Permanente’s health risk appraisal tool where 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/tha. Based on the responses, participants receive health activities they can do in their daily lives, tips on how to stay aware of their habits and make changes that last and tools and resources to help jumpstart their wellness journeys, including online HLPs.

The following are some features of the THA program:

- Members complete an online questionnaire that asks some simple questions about their health and medical history. The questionnaire includes questions about diet, exercise habits, weight and other habits and behaviors that affect health.

- Based on answers to the questionnaire, members receive a personalized health summary to help them set and reach their health goals.
- The responses are strictly confidential. 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 target specific programs that help meet their 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
- Able to emphasize member's individual health history and personal habits
- Inclusive of 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 but not limited to, the Member Experience Tracking Evaluation and Opinion Research Survey (METEOR), Press Ganey Patient Satisfaction Survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), 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 Press Ganey Patient Survey is primarily administered via phone and mail.

Both the CAHPS and METEOR Surveys assess the patients' experiences with both health care received, customer service within the health plan and information about plan and benefits. The Press Ganey Patient survey follows a specific visit and focuses on patient satisfaction with their visit including appointment access and scheduling; physician's manner, attitude; overall visit satisfaction; and coordination of care.

5. PLAN FOR COORDINATION AND CONTINUITY OF CARE

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

Kaiser Permanente follows the Transition to Other Care and Authorization of Service Policies when assisting members with coordination and continuity of care within the Utilization Management department, along with coordination with the Care Continuum Population Health team for additional support and resources within the community.

The Utilization Management Professionals (UMPs) review approved clinical and medical and behavioral health criteria based on member needs, along with consulting the UM Physicians when applicable, to ensure our members are at the right level of care, at the right time, and in the right place.

Our member-centered approach ensures that member access to care is evaluated and determined by member individual needs, whether that be within the network of contracted providers or non-contracted providers for continuity of care to ensure our members are reaching their optimal function.

Services coordinated by the Population Health and Care Continuum teams include (but are not limited to): prevention and outreach, ancillary community providers, complex case management, care giver support, Meals on Wheels, clinical and behavioral health education, and transition of care management. These activities are completed based on member risk when the need arises.

C. Process for Ensuring Appropriate Discharge Planning

Members are informed about care alternatives during hospitalization as part of the hospital discharge planning process, in partnership with hospital case managers to assist with discharge needs.

Kaiser Permanente monitors all discharges via automatic notification through our electronic medical record. This allows for identification and stratification of discharging members to ensure appropriate follow up. Members are outreached by the Transitions Team, consisting of MAs and RNs, Specialty/Surgical care coordinators and/or RN's telephonically to assess needs, perform medication reconciliation and determine follow up needs. Follow up includes visits with primary care physicians, specialists, or in-home visit from an Advance Practice Nurse.

D. Process for Covered Persons to Choose and Change Primary Care Provider

Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have their own PCP.

Choosing Your Primary Care Provider

You may select a PCP from family medicine, pediatrics, or internal medicine. You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to

kp.org/locations. You can also get a copy of the directory by calling Member Services. To choose a PCP, sign into your account online, or call the Clinical Contact Center for help choosing a PCP.

Changing Your Primary Care Provider
Please call the Clinical Contact Center to change your PCP. You may also change your PCP online or when visiting a Medical Office Building. You may change your PCP at any time.

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. This letter includes instructions on how to transfer your care to another provider. 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.