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 multispecialty 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 Kaiser Permanente.org/locations. On weekends, the East Denver, Lakewood, Lone Tree, and Westminster Medical Offices are open. Lakewood, Lone Tree, and Westminster Medical Offices are open on Saturday and Sunday from 8 a.m. to 6 p.m. East Denver Medical Offices are open Saturday from 8 a.m. to 4 p.m. and Sunday 9 a.m. to 4 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, and Pueblo North Medical Offices in Southern Colorado; Loveland, Fort Collins, Greeley, and Spring Creek Medical Offices in Northern Colorado; and Edwards and Frisco Medical Offices.

The Kaiser Permanente website, Kaiser Permanente.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 Call Center. Members can call 303-338-4545 (TTY 711) from 7 a.m. to 6 p.m., Monday through Friday, to schedule an appointment. Members can call that same number for medical advice 24 hours a day, seven days a week. Most of the time, members are seen the same day or at least within 7 days from the time that they call for routine care appointments. Urgent care services are available to members within 24 hours.
Appointments and advice are also available through Kaiser Permanente’s website, KaiserPermanente.org.

Members are encouraged to call the Appointment and Advice Call 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: Saint Joseph Hospital, Good Samaritan Medical Center, SCL Health Emergency Center, 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, Children’s Hospital Colorado Urgent and Outpatient Specialty Care–Uptown Denver, or Rocky Mountain Hospital for Children. These hospitals are open 24 hours a day providing emergency care.

Denver/Boulder Service Area

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 provider. 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 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, OBGYN**: Kaiser Permanente utilizes its integrated delivery system to provide OB/GYN care for its membership. Access to care through meeting a 1:1000 provider to enrollee ratio for members in the service area boundary counties as well as the driving distance standard ensures adequate women’s health services for this population.

- **Pediatricians**: Kaiser Permanente offers pediatrics services through its medical office locations to offer Pediatric services. Kaiser Permanente also ensures that it’s 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 two Kaiser Permanente behavioral health offices as well as accessibility to an extensive network of contracted behavioral health facilities and providers in the Denver metropolitan area to support routine, urgent, and emergent behavioral health care services. A 1:1000 provider to enrollee ratio is maintained for behavioral health availability in the Denver/Boulder region.

- **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 for all of 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 in a four quadrant set up through its medical office building locations in the Lakewood, East Denver, Lone Tree, and Westminster areas 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 5 medical office locations that offer routine and urgent behavioral health care services. In addition, 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, are trained and equipped to provide care by video. All primary and received training in video visits by December 31st, 2016. Kaiser Permanente CO does not currently have documentation that addresses how the use of telemedicine or telehealth or other technology may be used to meet network access standards.

• 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 provider and facilities as well as sufficient geographic access (driving distance from member’s home address).

Though Kaiser Permanente of Colorado currently meets the adequacy threshold for driving distance standards to certain behavioral health providers, Kaiser Permanente is currently considering multiple interventions to improve accessibility for patient access to waiting time standards for behavioral health services including:

- Increased staffing (2016 to date): 28 Therapists, 5 RNs, recruiting 2 APNs, contracted with 7 Psychiatrist Locums, contracted with APN Locums
- Activated Overflow referrals to external network providers at a rate of approximately 2.5 FTE
- Development of new models of care
- Development of a Forecast tool to project access performance into the future
- Streamline and Accelerate recruiting and credentialing processes
- Explore and expand external network contracting options
- Bi-Weekly Access Accountability to National Leaders
- Bi-Weekly Access Meeting with Local Leaders
- Transitioning organizational reporting to reflect Urgent requirement for % within 24 hours; Routine to % within 7 days
- 7 average days wait is expected by 07/08/2017

B. Monitoring the Sufficiency of Network

Kaiser Permanente CO 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.

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 insure that any changes in availability or composition of their practices are documented. Kaiser Permanente performs a quarterly outreach to its entire provider network to the accuracy of their provider group profile that is on record in the provider database that feeds to the online directory, Kaiser Permanente.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 insure 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 (KAISER PERMANENTE CO) is the state’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 47 years and employ more than 7,000 staff and physicians, representing several medical specialties and major subspecialties. Kaiser Permanente provides care for more than 665,219 members in Denver, Boulder, Southern Colorado, Northern Colorado, and Mountain Colorado.

The Kaiser Foundation Health Plan and Hospitals National Boards of Directors (the Boards)
have ultimate accountability and responsibility for the quality of care and service provided to all Kaiser Permanente members in the eight regions. The Boards established the Quality and Health Improvement Committee (QHIC), which, in conjunction with the Kaiser Permanente National Quality Committee (KAISER PERMANENTENQC), oversees the quality and safety of care and service provided to Kaiser Permanente members. The QHIC and the KAISER PERMANENTENQC hold the Colorado Regional President of the KFHP of Colorado and the President and Executive Medical Director of the CPMG responsible for the day-to-day quality of care, service, safety and cost-effectiveness provided to members in the Colorado region of Kaiser Permanente.

The Regional SQRMC is charged with developing, implementing and overseeing Quality, Resource Stewardship, Service Improvement activity and Patient Safety in the Colorado region, which includes the following responsibilities: policy decisions, analyzing and evaluating quality improvement activities, instituting needed actions, and ensuring follow up. The Regional SQRMC monitors outcomes of care to ensure consistent high quality, affordable, accessible health care to all our members. The Regional SQRMC is a standing committee that meets monthly and is co-chaired (on a rotating basis) by the VP, Value and Resource Stewardship (CPMG), the VP & Chief Quality Officer (CPMG), and the VP of Quality and Innovation (HP).

The Kaiser Permanente CO Integrated Patient Care Quality (IPCQ) Program Description outlines the quality assurance standards, which identifies, evaluates and remedies problems relating to quality of care, continuity, service (including access), resource management, patient safety, risk management and behavioral health. The structure and effectiveness of the IPCQ Program, which include the IPCQ Program Description, Work Plan and Program Evaluation are evaluated and approved at least annually by the Regional Service Quality and Resource Management Committee (SQRMC) to ensure the program is deemed adequate.

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 through 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 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 Kaiser Permanente.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.

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.

**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 Central Referral Center 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 Kaiser Permanente.org. Members may obtain a printed copy of the Membership Agreement or Evidence of Coverage 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 Membership Agreement / 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 Medical Care

• Process for Choosing and Changing Network Providers

• Covered Persons with Limited English Proficiency and Illiteracy
  Access to Services for Foreign Language Speakers
  1. Member Services will provide a telephone interpreter to assist Members who speak limited or no English.
  2. Plan Physicians have telephone access to interpreters in over 150 languages.
  3. Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
  4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

Also refer to “Diversity and Inclusion Center of Expertise Program” section below for further details of Kaiser Permanente’s processes for addressing the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; and the process to identify the potential need of special populations.

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

Kaiser Permanente.org website includes information on the following:

• Kaiser Permanente partners with HealthMedia, Inc., a Michigan-based organization that specializes in creating self-management programs for healthy lifestyles, for providing members with a health risk appraisal. 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 KaiserPermanente.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 report is also provided to the member’s PCP.

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, KaiserPermanente.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.

**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.

The Clinic Profile data sheet was developed by the Equity Care Collaborative in order to show demographic information, ECHO (Equitable Care Health Outcomes) information and Diversity & Inclusion data for each medical office building with the purpose of closing health disparities.

The CLAS (Culturally, Linguistically, Appropriate Services) assessment is done by the Workforce Diversity Specialist and reported regionally with the purpose of tracking and monitoring progress over time, as well as identifying opportunities for improvement and targeted interventions of all 15 standards in CLAS.

**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 Health Plans Survey
(CAHPS), Art of Medicine, and the review and evaluation of complaints and appeals. While METEOR is a phone survey of members, the Patient Satisfaction Survey is a large phone survey of patients following a specific medical office visit. The Art of Medicine survey is a mail survey of members following a specific visit and focuses on member’s satisfaction with their individual physician’s manner, attitude and quality. 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**
KAISER PERMANENTE is committed to the Diversity and Inclusion Strategy and acknowledges that it is a key business strategy essential to maintaining high-quality, best service, affordable health care and making KAISER PERMANENTE the best place to work. The program is guided by the National Diversity and Inclusion Department, which serves as a national policy advisor to leadership and a sponsor of strategic initiatives to advance the Diversity and Inclusion Strategy and meet regulatory requirements.

**Purpose and Goals**
The mission of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion is to develop a climate focused on the elimination of health disparities of members and their communities by integrating diversity and inclusion into all aspects of the organization by ensuring a diverse and culturally competent workforce. As part of this mission, the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion assesses cultural and linguistic needs and preferences of the member population and compares these against the current workforce and regional demographics.

Consistent with its mission, the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion oversees a comprehensive diversity strategic plan, developed and endorsed by the National Diversity and Inclusion Council, focusing on integrating diversity and inclusion into all aspects of the organization. The Office will focus on the following objectives to achieve the above mission:
• Identify barriers in the delivery of health care to diverse populations
• Identify our member 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 practitioners within each service area.
• Evaluate, track and document best practices, and share them with other KAISER PERMANENTE regions; and
• Support membership growth through ensuring we have a diverse workforce aligned with specific populations that are emerging segments of society;

The following sections describe the components of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion, the functions and accountabilities and the various monitors for evaluating the program in the Colorado region.

Structure and Approach
Kaiser Permanente CO 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 Kaiser Permanente CO service areas.

The Director of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion provides oversight and direction to the Diversity and Inclusion Strategy. The Director of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion reports to the Vice President of Human Resource for Health Plan and CPMG and is responsible for directing and managing all of the components of the program and ensuring integration into all aspects of the organization. Guidance is provided through a regional executive sponsor team consisting of KFHP Regional President, President and Chief Medical Officer, and Operational Vice Presidents from both Health Plan and CPMG.

The Kaiser Permanente CO Office of Diversity, Equity, and Inclusion Director works in partnership 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 ECHO measures to identify disparities.

Collection of race, ethnicity and language preference data is performed in the clinical setting by Nursing Services. Quality, and services departments determine gaps and develop action plans. Operations implements regulations, directives and action plans in the clinical setting. The Kaiser Permanente CO Office of Diversity, Equity, and Inclusion conducts a wide range of services, training materials and courses to aid physicians and staff to understand our membership and deliver culturally competent care to our patients.
Roles and Responsibilities

*Kaiser Foundation Health Plan (KFHP)*
The Director of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion provides oversight and leadership for the Diversity and Inclusion Strategy and partners with Health Plan and CPMG executive leadership in ensuring the implementation of the national diversity agenda and execution of regional goals and objectives. The Kaiser Permanente CO Office of Diversity, Equity, and Inclusion provides leadership for the Equity Care Collaborative which is a partnership between Health Plan and CPMG.

The Senior Diversity Learning Consultant provides leadership, expertise, and coaching for the diversity and inclusion education program, which is designed to build cultural competence skills, enhance responsiveness to diverse cultures and improve health care equity. This role leads the Equitable Care Cultural Sensitivity Council, which is an interdisciplinary leadership team who engages all levels of the organization to increase cultural awareness, sensitivity, and equity for our diverse workforce and member population. The Senior Diversity Learning Consultant is responsible for the management of the Diversity Navigators and Diversity Teaching Associates Program, as well as provides oversight to ensure the integration of diversity, equity, and inclusion into leadership development and functional excellence programs.

The Workforce Diversity Specialist/Qualified Bilingual Staff Program Manager works closely with the Recruiting Team and Hiring Managers to educate and meet their AA goals. The Workforce Diversity Specialist/Qualified Bilingual Staff Program Manager acts as the point person for any OFCCP Reviews or Audits. He/she leads the Culturally and Linguistically Appropriate Services (CLAS) Strategy for the region, educating and informing about CLAS, accepting, tracking, investigating and resolving CLAS Complaints. The Workforce Diversity Specialist leads the regional Linguistic Strategy for the region. Educating and promoting language assessment for bilingual staff, tracking bilingual staff and the needs of the region. Coordinates Qualified Bilingual Services (QBS) Training and prepares reports for leadership. The Workforce Diversity Specialist develops and maintains the diversity recognition program to recognize individuals and groups in the region that advance the Diversity and Inclusion Strategy.

The Diversity Relations and Community Outreach Specialist promotes the advancement of diversity through community service, advocacy efforts and educational programs. The Coordinator works with academic institutions, organizations and community leaders to create and strengthen community partnerships to serve the health and well-being of diverse populations; develops interventions for social determinants of health and disparities; and works to optimize community investments.

Completion of higher education and the acceptance to professional and/or graduate school within healthcare professions are common ambitions for many students in the state of Colorado. The enrollment rates of underrepresented populations in higher education are low and their graduation rates are even lower (APA, 2014). Kaiser Permanente CO Academic Relations programs are designed to provide mentorship, academic and community support, internships, and networking opportunities to help increase the number of traditionally underrepresented individuals within the health care professions. The ingredient that sets our programming apart...
from many programs aiming to increase diversity in higher education is that that our programs not only includes ethnic minorities, but also incorporates first generation, individuals with a disability, and veteran groups.

**Diversity Committees Structure**

*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, the Executive Director of the Permanente Federation and Kaiser Permanente Program Group (KAISER PERMANENTEPG). 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.

**Multicultural Business Resource Groups**
The Multicultural Business Resource Groups collaborate with the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion:
- Partner with Community Benefit regarding outreach designed to increase and retain membership.
- Engage in activities that reduce health care disparities and inequities.
- Align with recruiting to increase diverse representation within the organization.
- Serve as a feeder group for succession planning and career development within the organization.

**Program Content**
The Kaiser Permanente CO Office of Diversity, Equity, and Inclusion adopted the following initiatives to deliver and implement the Diversity and Inclusion Strategy:
- Develop culturally competent leaders and providers: Prepare our providers and staff to provide culturally appropriate medical care and services to improve the health and satisfaction of our increasingly diverse membership.
- Recruit, hire and promote diversity: Enhance the diversity of our workforce to reflect the communities we serve and address the needs of all our members.
- Identify, grow and leverage diverse leaders: Retain, engage, promote and leverage diverse leaders to ensure that the organization benefits from their diverse perspectives, knowledge and experiences.
• Membership growth and retention: Grow our membership through effective market segmentation approaches targeting the specific populations that are the fastest growing segments of our society.
• Academic Relations: Engage with academic institutions for internships and mentorships that help diversify our recruiting pools.
• Compliance: Fulfill applicable diversity requirements and guidelines, including mandatory and voluntary governmental regulations and/or accrediting body standards.
• Community Benefit: Improve the health of and enhance our ties to the diverse communities we serve.
• Supplier diversity: Include small businesses and those owned by minorities, women and veterans in the company’s overall supplier and contractor base.

These initiatives are integrated into every area of the organization, including health care delivery, and are communicated to members and employees through different venues, such as newsletters, website and the employee portal.

Multicultural Business Resource Groups consist of racial, ethnic, disability, veteran, sexual orientation and gender identity, and multi-generational affinity groups, which are a rich source of cultural expertise and primary links to community segments. Multicultural Business Resource Groups play a critical role in providing cultural knowledge to inform the development of product and business initiatives as well as essential community advocacy and feedback to the program. The groups also provide leadership development opportunities to diverse emerging talent. Among their specific areas of focus are workforce diversity, organizational effectiveness, care delivery and marketplace and community relations.

The Language Resource Center (LRC) is a department under the Appointment and Advice Clinical Contact center, it was established to better serve members with limited proficiency in English. The LRC has a staff of dedicated employees focused on breaking down the barriers that often get in the way of providing exceptional care experiences for all members. The LRC has five Spanish interpreters, who provide services for those members who may need assistance with requesting an appointment, registering a complaint or appeal, seeking information about their benefits, seeking medical advice from their primary care physician and/or nursing staff, requesting information about pharmacy, when calling the AACC or at the Skyline and Franklin campus. The LRC staff is familiar with the organization’s system and is competent in medical interpretation. In addition, Kaiser Permanente CO contracts with external agencies, such as Pacific Interpreters, Mile High Multilingual Services and others, to provide interpretation services for almost 200 languages, 24 hours a day, 7 days a week.

Kaiser Permanente CO provides notification to physicians, staff and members about the availability of these services, training programs and materials. Members are informed of the availability of language services through the newsletter “Partners in Health,” the Member Resource Guide and through the member website. In addition, the medical staff directory located on the member website also contains information about languages spoken by the physicians and their staff. Physicians and staff receive notification about services, training and materials through the bi-weekly newsletter, “Newsbreak,” as well as through the employee portal.
Workforce diversity is another important aspect of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion. Kaiser Permanente CO 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. Kaiser Permanente CO 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 Kaiser Permanente CO Office of Diversity, Equity, and Inclusion to reach out to diverse populations by actively networking, advertising, attending and participating in various culturally diverse career fairs and events.

Program Monitoring
All goals and activities related to the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion are included on the annual Service, Quality and Resource Stewardship Work Plan. The effectiveness of the program plan and objectives is reviewed annually and reported through the annual Service, Quality and Resource Stewardship Program Evaluation. The Kaiser Permanente CO Office of Diversity, Equity, and Inclusion reports status of diversity goals as part of the Human Resources’ presentation to the Regional SQRMC. The Work Plan and Program Evaluation are also presented to Regional SQRMC at least annually for review and approval.

Annual Review
The structure and effectiveness of the Kaiser Permanente CO Office of Diversity, Equity, and Inclusion are evaluated, at least annually, by the HP VP and CPMG HR VP, Executive Sponsors, and National Diversity and Inclusion Office and approved by the Regional SQRMC. The Diversity and Inclusion Strategy is reviewed at least every two years and revised as needed.

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 or readmission and is scored across these four elements: Length of stay, Acuity, Comorbidities, ED visits in last 6 months). For members assessed as high risk for readmission (9-15) and discharged to home a Post-Acute Care Transition (PACT) Advanced Practice Nurse (APN) schedules an in-home visit to assess condition, ensure PCP follow-up, and refer to ongoing care coordination where applicable. At risk members receive care from a Care Management Team (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).

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:

1. **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. Please refer to the “Second Opinions” section below.

   **Second Opinions**
   Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

   You may choose your PCP from our provider directory. To review a list of Plan Physicians and their biographies, visit our website. Go to [Kaiser Permanente.org/locations](http://Kaiser Permanente.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, accepting new patients, based on your health care needs.

2. **Changing Your Primary Care Provider**
   Please call Personal Physician Selection Services to change your PCP. You may also change your PCP when visiting a Plan Facility. 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 or 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 discontinuing services could cause a recurrence or worsening of the condition under treatment and/or interference with anticipated outcomes. 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.
### Accessibility Standards

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### Geographic Access Standards

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