2024 SB 546 Report (2024 Filing)– Q-14 Cost Containment – KPIC Response

This response applies to Kaiser Permanente Insurance Company's (KPIC's) PPO and OOA products and tiers 2 and 3 of the POS products.

I. Administration of Outpatient Prescription Drug Benefit by KPIC's Pharmacy Benefit Manager (PBM)

Since 2017, KPIC's Pharmacy Benefit Manager (PBM) has continued full administration of KPIC's outpatient prescription drug benefit. This includes maintenance of the formulary, utilization of the PBM's Pharmacy & Therapeutics and Formulary Committee (P&T Committee), and adoption of its cost containment processes. KPIC formularies, pharmacy utilization management edits and supporting medication treatment guidelines are reviewed and approved by PBM's P&T Committee and are based upon a thorough review of the medical literature reflecting published treatment guidelines recommended by national medical organizations. The P&T Committee reviews key therapeutic drug categories on a continuous basis to ensure they reflect the most up to date medication treatment recommendations.

Drugs presented to the P&T Committee for consideration are reviewed on the following evidence-based criteria:

1. Safety, including concurrent drug utilization review (cDUR) when applicable,
2. Efficacy: the potential outcome of treatment under optimal circumstances,
3. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary,
4. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available,
5. Relevant benefits of current formulary agents of similar use,
6. Condition of potential duplication of similar drugs currently on formulary,
7. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

KPIC's PBM monitors the ability of the utilization management programs applied at point of sale to ensure that KPIC delivers a highly efficient cost effective pharmacy benefit program to our membership.

KPIC's PBM also received NCQA Utilization Management (UM) Accreditation in 2017. This accreditation demonstrates that KPIC's PBM has the systems, processes and personnel to conduct utilization management in accordance with the strictest quality standards with focus on quality through consumer protection and improvement in service to customers with emphasis that organizations continually work on quality improvement. Some areas of focus:

- The PBM has the quality improvement infrastructure needed to improve the UM functions and services provided to its members.
- The PBM has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.
- The PBM applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

- The PBM continually assesses member and practitioner experience with its UM process to identify areas in need of improvement.

Drugs requiring prior authorization:
Prior authorization is generally applied to drugs that have multiple indications, qualify as Specialty medications per our protocol, are high in cost, have a high abuse potential (topical testosterone) or have a significant safety concern.

Drugs requiring step therapy:
Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Under step therapy, KPIC insureds may first need to try a proven, cost-effective medication before using a more costly treatment.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the insured's drug history, prior to the use of another drug (2nd line agent). If the licensed prescribing provider determines that a first-line drug is not appropriate or effective, a second-line drug, may be covered after meeting certain conditions.

II. Quality Management, Utilization Management, and Case Management by KPIC's delegated entity

KPIC's delegated entity, Permanente Advantage (PA), provides quality management, utilization management, and case management of care and services to KPIC's insureds.

1. **Quality Management Program.** The purpose of the Quality Management Program Description (QMPD) for Permanente Advantage (PA) is to assess and oversee the quality of care and services provided to Kaiser Permanente Insurance Company (KPIC) members throughout the continuum of care by non-KP practitioners and providers.

   The scope of the PA QMPD is limited to Preferred Provider Organization (PPO) or Point of Service (POS) members receiving care by non-KP practitioners and providers. POS members must be utilizing their tier 2 or tier 3 benefits to fall under the PA QMPD, otherwise the oversight of their care will be performed by the KP Regional Quality Program. The Program's activities are developed and implemented in compliance with state and federal regulations and are approved by the PA Quality Management Committee (QMC).

   Permanente Advantage (PA) Board of Managers (PBAM) has granted authority to the QMC for oversight of the Quality Management Program. The QMC is responsible for oversight and direction of the Permanente Advantage QM Program. The QMC recommends policy decisions, reviews and evaluates the results of all QM activities, oversees implementation of action plans and ensures follow-up as appropriate. The QMC meets at least quarterly and may meet more frequently if deemed necessary by the Committee Chair or the PABM.

   A. The functions of the QMC include, but are not limited to:
      1. Monitoring of clinical cases by peer review.
      2. Approve the Quality Management Program Description and work plan annually.

3. Review of clinical decision-making processes for resource utilization and quality of care referred from UM Committee (UMC).
4. Monitors key clinical quality indicators and benchmarks and identifies areas requiring focused review.
5. Monitor data and outcomes of member and provider satisfaction, complaints, grievances and appeals.
6. Reviewing, approving, or facilitating physician and/or provider education.
7. As appropriate, providing feedback to Regional and National Network management regarding provider network quality and/or access issues and/or education (Network is contracted with KPIC).
8. Maintains approved minutes of all QMC meetings

B. The members of the QM Committee include the following persons/representatives:
   1. PA Medical Director and QM Chairperson
   2. Federation Associate Medical Director for Quality
   3. PA Director of Care Management
   4. KFHP Resource Stewardship
   5. Behavioral Health Practitioner
   6. Physician representatives from KP regions

The goals and objectives of the PA QMPD are to:

A. Maintain a clearly defined Quality Management (QM) Program structure.
   1. Involve physicians in the QM Program through participation in the QMC.
   2. Ensure adequate staff and resources are available for implementation and maintenance of the QM Program.
   3. Ensure that all appropriate quality issues are reported to the QMC.
   4. Ensure issues addressed by the QMC are communicated to the Permanente Advantage Board of Managers (PABM) to facilitate its oversight of the Program.
   5. Promote a quality improvement approach to issue resolution and process enhancement.
   6. Communicate the results of studies, audits, and surveys to all staff.

B. Continuously improve the quality of care and services.
   1. Maintain no less than two (2) quality improvement projects per accreditation program that address performance improvement and/or opportunities to reduce errors.
   2. Ensure accurate and valid data collected for baseline, and re-measure level of performance at least annually for QM activities.
   3. Document changes or improvements relative to baseline measurement and conduct an analysis if goals are not met.
   4. Monitor adverse outcomes for trends and implement action plans as appropriate.
   5. Use of clinical practice guidelines (nationally recognized) as appropriate.

The Quality Management Program will be reviewed, revised and updated annually. The evaluation process includes a summary of activities accomplished over the year and the impact of the activities on the provision of patient care and service. The QM Program may be amended by a majority vote of the PA Board of Managers, QM Committee or upon recommendation of the PA Care Management Director and the Medical Director.

2. **Utilization Management.** The purpose of the PA Utilization Management (UM) Program Description is to identify components of the UM Program, roles and responsibilities of the UM staff, and to provide the framework for activities scheduled for the current year. PA has established a formal process for the oversight of resource utilization as defined in the UM Program Description and measured in the work plan and annual UM Program evaluation.

   The PA UM Program will be applied equitably, and in compliance with existing Kaiser Permanente (KP) governance and administrative policies. Health care will be based on quality and appropriateness of care. Care will not be restricted on a cost basis and clinical review is not a guarantee of payment. Payment is always subject to member eligibility and available benefits at the date of service.

   PA does not use financial incentives to encourage barriers to care or service and does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, or to promote under-utilization.

   The UM Program Description will be updated, reviewed, and approved by the PA UM Committee, Medical Director, and Director of Care Management, annually or more frequently as necessary.

   The purpose of the UM Program is to provide a comprehensive process in which reviews of inpatient and outpatient services are performed in accordance with the requirements of the Kaiser Permanente Insurance Company (KPIC) Group Policy (Certificate of Insurance and Schedule of Coverage). While the optimal scenario is for all Preferred Provider Organization (PPO) and Point of Service (POS) members to receive care within the KP delivery system, the PPO/POS environment is structured to allow such members to obtain care outside of that system from either a KP-contracted provider network, or a provider of the member's choice. The UM Program is designed to assure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner. The focus of the Program is to ensure efficiency and continuity by identifying, evaluating, monitoring, and correcting matters that affect the overall efficacy of the UM process. The Program's activities are developed and implemented in compliance with state and federal regulations and are approved by the PA Board of Managers (PABM) and the PA UM/QM Committee.

   Permanente Advantage is URAC accredited in Health Utilization Management.

   This Program provides for fair and consistent evaluation of medical necessity and appropriateness of care through the use of KP and nationally accepted clinical practice standards.

   KP practitioners are included in the UM processes through participation in the various UM/QM Committees, which are functional components of the Program.

   The scope of the UM Program includes the following:

   A. Maintain a clearly defined Utilization Management Program structure.
      1. Involve providers in the UM Program through participation in the UM Committee, and through regular written communication with providers about the program.
      2. Ensure adequate staff and resources are available for implementation and maintenance of the UM Program.

3. Ensure issues addressed by the UM/QM Committees are communicated to the PABM, Quality of Care Committee, and the KPIC Board of Directors to facilitate Program oversight.
4. Coordinate with Regional and National Network Management to educate contracted providers on policies, procedures, goals, and objectives of the UM/QM Program, and to ensure compliance

B. Provide ongoing monitoring and evaluation to address and correct inefficient coordination of health care.
   1. Perform prospective review of specific health care services to ensure services are provided within established guidelines and benefits of the member's plan.
   2. Monitor, evaluate, and optimize health care resource utilization by applying evidence-based criteria for medical necessity review.
   3. Perform medical management for acute inpatient hospitalizations and skilled nursing facility care to include:
      i. Pre-admission, admission, concurrent review, and discharge planning to ensure medical necessity, appropriate level of care, and timely services.
      ii. Follow-up communication with patient, physician, and provider to ensure adherence to discharge plan, and avoidance of post discharge complications.
   4. Medical Director review of all potential or actual clinical denials, excluding denials due to non-eligibility and non-benefit coverage.
   5. Perform retrospective review of health care services rendered to validate appropriateness of service.

C. Identify members through screening criteria appropriate for case or disease management and develop interventions that ensure efficient delivery of care.
   1. Identify and manage members with catastrophic, complex, or chronic illnesses.
   2. Refer members with targeted diagnoses to disease management programs.

D. Integrate the UM Program within the QM Program, where appropriate.
   1. Monitor both inpatient and outpatient care for possible quality of care deficiencies, utilizing referral indicator screening criteria, and report to the QM department.
   2. Respond to member or provider complaints or single level appeals after comprehensive and timely investigations associated with utilization issues.
   3. Perform peer review in conjunction with QM Program, when necessary.

E. Monitor for over and under-utilization trends that may lead to quality of care concerns and implement appropriate interventions when indicated.
   1. Analyze utilization, readmission, pharmacy, appeals and grievance, and claims data to identify adverse trends or recurrent patterns indicating over or under utilization.
   2. Measure effectiveness of interventions implemented to address over or under utilization, as indicated.

F. Promote legislative and regulatory compliance as applicable to the organizational structure and care delivery model.
   1. Utilize a continuous quality improvement approach in the development, implementation, and evaluation of the UM Program.
   2. Assure governmental and other regulatory guidelines, standards, and criteria are adhered to, and submit required documentation to demonstrate compliance.

3. **Case Management.** The purpose of the PA Case Management (CM) Program is to provide and ensure the necessary tools are available to the Case Manager from the initial assessment, development of treatment plan and ongoing management of the case managed member. The

goal is to achieve the desired outcomes by providing quality care across a continuum enhancing quality of life and containing costs.

Case Management is defined by the Commission for Case Manager Certification (CCMC) as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Case Management will be performed on specifically identified members who have experienced a critical event or diagnosis requiring extensive use of resources and requires assistance in navigating the healthcare system to facilitate appropriate delivery of care and services.

Case Management is a service available to all Kaiser Permanente Insurance Company (KPIC) members. Members have the right to decline participation or dis-enroll from the Case Management Program. Permanente Advantage is URAC accredited in Case Management.

A. **Member Identification -** Members are identified for referrals to the Case Management Program via several data and personnel sources. This includes but is not limited to:
   1. Diagnosis data (cancer, trauma, chronic conditions)
   2. Claims data (high dollar, high utilizers)
   3. Authorization data (census and discharge)
   4. Physicians, providers, discharge planners, vendors
   5. PA Care Management staff and other Kaiser staff
   6. Disease Management program or specific conditions
   7. Member, family and/or caregiver

B. **Assessment**

   Members who are enrolled in the Case Management Program are engaged in a detailed documented assessment of overall health status and condition specific issues pertaining to:
   1. Clinical history (medical issues)
   2. Activities of daily living (ADL)
   3. Mental Health status (psychological, psychosocial)
   4. Life planning
   5. Cultural, health literacy, and/or linguistic factors, preferences or limitations
   6. Family, caregiver and/or community support
   7. Financial factors and/or resources
   8. Continuity and coordination of care (immediate and future)
   9. Benefits (available and/or needed)

C. **Opportunity Identification**

   Member, family, caregiver, and the healthcare team are essential participants in problem identification.

   Problems identified for Case Management intervention where members outcomes can be positively influenced includes but is not limited to:
   1. Lack of established or ineffective treatment plan
   2. Compromised patient safety
   3. Inappropriate utilization of services
   4. Alterations in function

5. Non-adherence to medication or treatment
6. Lack of medication or treatment knowledge
7. Lack of social or financial resources

Identification of referrals to Regional Kaiser Permanente (KP) Disease Management and/or other applicable programs.

D. **Development of Case Management Care Plan**

Collaboration with member, family, and/or caregiver and the multidisciplinary team, results in development of a member centered care plan, with ensuing follow-up dates determined by evidence-based algorithms utilized in the Case Management Documentation system to include:

1. Development of a member centered care plan including short- and long-term goals
2. Resources utilized and interventions with timelines to meet goals
3. Identification of care needs and barriers to meeting or complying with plan
4. Development of follow-up schedule and communication with member and physician
5. Development and communication of self management plans for members
6. Process to assess progress against the member centered care plan
7. Maximize member's health, wellness, safety, self-care and support independence in decision making.

E. **Implementation**

Case Management plan of care is put into action by facilitating coordination of care, services, resources, and health education specific in the planned interventions

Collaboration with the member, family, and/or caregiver and multidisciplinary team, including physician(s).

F. **Monitoring**

Develops a process of ongoing assessment and documentation to monitor the quality of care, services and products delivered to the member. Assess knowledge and adherence to member centered care plan and medications. Assesses if the goals of the member centered care plan are achieved, remain appropriate and realistic and revise if appropriate.

G. **Evaluation**

Employs a methodology designed to measure healthcare and case management process focusing on response to the member's centered plan. The evaluation process occurs over specific time frames and is a continuous process. The evaluation process encourages in-put from the member, family and healthcare team to appropriately determine the impact of case management and healthcare interventions.

H. **Closure of Case Management services**

Establish criteria for discharge of members or termination of Case Management services.

Bring mutually agreed upon closure to the member-case manager relationship and engagement in Case management recovery. The best possible outcomes, or when needs and desires of the member has changed.

I. **Outcomes**

Case Management is a goal-directed process. Identification and implementation of changes in the Care Management plan to produce outcomes that are positive, measurable and goal-oriented.