October, 2016

Re: Annual NCQA Update

Kaiser Permanente (KP) would like to take this opportunity to communicate and reaffirm our longstanding policies regarding open Member-Practitioner communication, protection of Members’ confidentiality and privacy, access and availability, access to care decisions, medical record expectations, and other aspects of our Quality and Utilization Management/Resource Management Programs.

**Non-discrimination and Member-Practitioner Communication**

A basic value of KP is that patients are treated with sensitivity, dignity, and respect, while receiving quality care.

In keeping with these values, KP does not discriminate in the delivery of health care services based on race/ethnicity, color, national origin, ancestry, citizenship, immigration status, culture, languages spoken, religion, sex (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person’s assigned sex at birth), marital status, veteran’s status, sexual orientation, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), or source of payment.

It is also the policy of KP to require that our facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 (“ADA”) and Section 504 of the Rehabilitation Act of 1973 (“Section 504”) and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability. All KP employees have access to the text of the Civil Rights Act of 1964, the Age Discrimination Act of 1973, Section 504 of the Rehabilitation Act of 1973, and the ADA.

We believe that quality of health care includes a full and open discussion with each patient regarding all aspects of medical care and treatment alternatives, without regard to benefit coverage limitations, while maintaining confidentiality consistent with the confidentiality policies set forth by KP. Conforming to these long standing values, KP allows open Member-Practitioner communication regarding appropriate treatment alternatives, and does not penalize practitioners for discussing all available care options with all Members.

**Confidentiality Privacy and Security Policy Statement**

KP maintains policies regarding the confidentiality, privacy and security of Member-identifiable information including policies related to access to protected health information (PHI), protection of PHI in all settings, the use of data for quality management, and disclosure of information to Members’ employers. PHI may be in “oral, written, or electronic form”. KP’s workforce (employees, physicians, volunteers, trainees, or other persons who work for KP, or work on its premises, and are under its control, even if another organization pays them) is required to maintain the confidentiality, privacy and security of Member information. This obligation is addressed in policies and procedures and confidentiality notices and agreements. All Providers and their staff are subject to KP’s confidentiality, privacy and security requirements. KP has developed and distributed to Members a Notice of Privacy Practices describing Members’ privacy rights and KP’s obligation to protect Members’ health information.
Members have the right to privacy. KP will not release PHI without written authorization, except as required or permitted by law. If the Member is unable to provide authorization, the Member's legally authorized representative (AOR) may provide authorization for the release of information on the Member's behalf. Member -identifiable PHI is shared with employers only with the Member's permission or as otherwise required or permitted by law.

Members have a qualified right to access their own PHI, as provided by law. Members also have the right to authorize, in accordance with applicable law, the release of their own PHI to others.

KP may collect, use, and share PHI for treatment, payment and health care operations, and for other routine purposes, as permitted by law, such as for use in research KP, its workforce and Business Associates are required to protect the integrity, confidentiality, and availability of the ePHI (electronic PHI) to include media and device controls, physical safeguards for workstations, and limiting PHI access according to role-based employment. Providers who use, create, maintain, receive or transmit PHI must take security measures to control access to ePHI and protect it from alteration, destruction, loss, and accidental or intentional use by or disclosure to unauthorized persons.

For more information about rights regarding PHI as well as our privacy and security practices, you may call our Member Service Contact Center at (800) 464-4000 or 711 (TTY) or refer to our Notice of Privacy Practices on our website at the following link: http://members.kaiserpermanente.org/kpweb/privacystate/entrypage.do

Access and Availability

DMHC Timely Access Regulations that were implemented in early 2011 established access standards for primary care, specialty care, ancillary services, wait time for 24/7 triage/screening services and wait time for customer service. The intent of these regulations is to ensure that all health plans have adequate provider networks and staff sufficient for enrollees to access needed care and services in a timely manner. Kaiser Foundation Health Plan (KFHP) is providing oversight for these requirements by monitoring and reporting Kaiser Permanente Northern California (KPNC) performance results.

Notice of Primary Care Practitioner or Specialist Terminations

KP must notify Members affected by practitioner or group practice terminations at least sixty (60) calendar days prior to the effective date of termination. If the terminating primary care practitioner, primary care medical group, specialist or specialist group provides care to KPNC Members on an ongoing basis: (a) KFHP is responsible for notifying Members prior to the effective date of termination and assuring the transition and coordination of care where clinically indicated and (b) the primary care practitioner, specialist or specialist group is responsible for providing information and otherwise assisting KFHP in making such notifications. More specific information about practitioner terminations is available at http://kp.org/continuingyourcoverage or by calling (800) 464-4000.

Access to Care Decisions and Availability of Unitization Management (UM) Criteria/Guidelines

KPNC has several principles that guide the UM decision-making process. They include the following:

- Kaiser Permanente practitioners and contracted practitioners, and health care professionals make decisions about a Member’s care based on clinical needs in association with appropriate treatments and services. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.
- The health plan does not reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that result in denials or create barriers to care and services. In order to maintain and improve the health of Kaiser Members, including California’s Exchange Marketplace (“Covered California”), all
practitioners and health professionals must be diligent in identifying any potential under-utilization of care or service.

- UM criteria and guidelines are used in conjunction with clinical judgment, and case specific consideration. The following are considered when making UM determinations, (1) Member needs, such as age, co-morbidities, complications, home environment, psychosocial/cultural issues, patient safety and community resources, and (2) the capabilities of the local delivery system. When applicable, UM criteria/guidelines are used to guide UM decision-making.

- Only practitioners with current, unrestricted licenses make health care service denial decisions based on medical appropriateness or medical necessity. Board certified consultants are used to assist in making medical necessity determinations. The final decision regarding a Member's treatment plan rests with the treating physician. KP makes the UM criteria/guidelines available to its practitioners, providers and contracted practitioners and providers upon request.

- Copies of the UM criteria/guidelines are available by contacting the Member Service Contact Center at 1-800-464-4000 or 711 (TTY). For Practitioner and Member inquiries regarding UM issues, contact the local RM Department or the Coverage Decision Support Unit (CDSU). Appropriately trained professionals are available to answer questions you might have about our referral and authorization processes, criteria or other UM issues.

**UM Criteria and Guidelines**

UM Criteria/Guidelines used within KPNC are summarized in the chart below.

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<th>NCAL UM CRITERIA/GUIDELINES</th>
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<td>- Behavioral Health Treatment for Autism Applied Behavioral Analysis (ABA) (Concurrent) not available in plan</td>
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<tr>
<td>- Transgender Surgery</td>
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<td>- Dental Anesthesia</td>
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Use of InterQual Criteria for Surgery and Diagnostic Imaging for the Central Valley Affiliates (CVA) only

**Denials and Practitioner Appeals**

Information about a denial or the appeal procedures is available by contacting your local UM department. Please refer to the last page of this communication document for a list of local UM departments and telephone numbers. When a benefits or medical necessity denial is made, the requesting practitioner is given the following information:

- Availability of UM Physician Reviewer: The name and direct telephone number of the decision-maker accompanies a copy of the denial letter that is sent to the requesting practitioner. All medical
necessity decisions are made by physicians. Physician decision-makers include, but are not limited to, DME physician champions, Assistant Physicians-in-Chief (APICs) for Outside Services (Referrals), other board certified or behavioral health practitioners. If the information is unclear, please contact the issuing department that is identified in the letter.

- If the physician or behavioral health practitioner does not agree with a medical necessity decision, the physician may contact the UM decision-maker on the cover page of the letter or the case may be discussed with the Physician-In-Chief (PIC) at the local facility. For additional information regarding this process, please contact your local RM Chief and/or local RM Department.

**Member Grievance Resolution**

KP is committed to providing our Members with quality care and ensuring prompt resolution of their grievances. Members may contact our Member Services Departments at any of our facilities or at the Member Service Contact Center at (800) 464-4000 or 711 (TTY) to voice their concerns or requests. Member Services representatives will advise Members about our resolution process and ensure that the appropriate parties review the Member’s grievance.

We will make every attempt to resolve the Member’s grievance promptly, and will resolve the issue as quickly as the member’s health requires, but no later than the regulatory required timeframes, within thirty (30) calendar days of receipt of the written or verbal complaint, in most cases. The Member or the Member’s physician may request an expedited review, resolved within seventy-two (72) hours, if the requested service or item had not been provided (preservice) or the requested service or item is currently being provided (concurrent) and the Member or physician believes the requested service or item is medically urgent.

Members should always refer to their Evidence of Coverage (EOC) for the grievance resolution options that are applicable.

**Independent Medical Review (IMR) Program**

California law requires health plans to offer an IMR program to Members who have been denied services because the services were deemed not medically necessary, or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Review Organization (IRO) Program is administered by the California Department of Managed Health Care (DMHC). If the DMHC determines that the Member's case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision. For additional information you may contact the Kaiser Member Service Contact Center at (800) 464-4000 or 711 (TTY).

**Member Rights and Responsibilities**

KPNC is responsible for informing practitioners about Member rights and responsibilities. Health care practitioners are expected to be familiar with the rights and responsibilities of our Members. The following is an abbreviated excerpt from the Rights and Responsibilities Section of *The Guidebook to Kaiser Permanente Services Northern California*. At enrollment, and annually thereafter, Members are notified on how to obtain the Guidebook containing the Member Rights and Responsibilities statement. If you would like a copy of the Guidebook please contact our Member Service Contact Center at (800) 464-4000 (English), (800) 788-0616 (Spanish), (800) 757-7585 (Chinese dialects), or 711 (TTY). This information is also available in expanded detail on our website at [http://members.kaiserpermanente.org](http://members.kaiserpermanente.org).

Members have the right to:

- Receive information about KP, our services, our practitioners and providers, and Member’s rights and responsibilities;
- Participate in a candid discussion of appropriate or medically necessary treatment options for their condition (s), regardless of cost or benefit coverage;
- Participate with practitioners in making decisions about health care;
• Have ethical issues considered;
• Receive personal medical records;
• Receive care with respect and recognition of their dignity;
• Interpreter services, including sign language, which shall be available during all hours of operation at no cost;
• Be assured of privacy and confidentiality;
• Participate in physician selection without interference;
• Receive a second opinion from an appropriately qualified medical practitioner;
• Receive and use Member satisfaction resources, including the right to voice complaints or appeals about KP or the care we provide;
• Make recommendations regarding KP Member rights and responsibilities policies.

Members are responsible for:
• Knowing the extent and limitations of health care benefits;
• Notifying us if hospitalized in a non-KP Hospital;
• Identifying themselves;
• Keeping appointments;
• Supplying information (to the extent possible) that KP and our practitioners and providers need in order to provide them with care;
• Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible;
• Following the plans and instructions for care they agreed on with their practitioners;
• Recognizing the effect of their lifestyle on health;
• Being considerate of others;
• Fulfilling financial obligations;
• Knowing about and using the Member satisfaction resources available to them, including the grievance-resolution process.

Evaluation of New Technology

KPNC maintains a rigorous process for evidenced based health care technology assessment. KPNC’s TPMG New Medical Technology addresses technology inquiries from KPNC’s TPMG physicians and Health Plan administrators with syntheses of pertinent clinical evidence and TPMG clinical expert opinion on the safety and efficacy of novel treatments and tests. TPMG New Medical Technology also participates in the Interregional New Technologies Committee (INTC) for timely and objective evaluations of new medical technologies and new applications of existing technologies to help programwide medical and behavioral health practitioners, all represented on the INTC, make informed clinical care decisions. Within KPNC, TPMG clinical chiefs’ groups and leadership decide which new technologies to integrate into TPMG clinical practice. As necessary, the KP California’s Benefits, Contracts and Policies Committee reviews medical technology deployment decisions to identify any impacts on Health Plan benefits.
Northern California Quality Program and Patient Safety Program

The KPNC Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation, licensing, and other elements. The quality improvement program assures that quality improvement is an ongoing priority of the organization. Quality activities can include, but are not limited to, quality improvement and peer review, identification of clinical and administrative system issues that impact care delivery, credentialing and privileging, submission of reports to state and federal regulatory bodies, and public reporting of data as governed by law and regulation.

Information about our quality program is available to you in the *Quality Program Description at KP* document, including:

- Awards and recognition for our quality program presented by outside organizations
- Programs and systems within KP that promote quality improvement
- Our quality improvement structure
- Areas targeted by our quality goals

To obtain a copy of this document, call our Member Service Contact Center at *(800) 464-4000* or **711 (TTY)**. Ask for a copy of *Quality Program at KP*. Alternatively, you can view and print the document by visiting the KP website at [http://www.kaiserpermanente.org](http://www.kaiserpermanente.org). Click on “Locate our Services,” select “Forms and Publications,” then “Quality Report” and finally “Quality Program at KP”.

At KP, patient safety is every Member’s right and everyone’s responsibility. As a leader in patient safety, our five-year strategic plan outlines six (6) focus areas. These themes include safe culture, safe care, safe staff, safe support systems, safe place, and safe patients.

If you would like independent information about KP’s health care quality and safety, the following external organizations offer information online:


- The Leapfrog Group is a group of Fortune 500, non-profit and private companies that encourages purchasers and consumers to use their health care buying power as leverage to implement quality and safety standards in the U.S. The group gathers information about aspects of medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. All KP hospitals in California participated in the most recent survey. To review survey results, visit the Leapfrog website at: [http://www.leapfroggroup.org/cp](http://www.leapfroggroup.org/cp).

- The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit: [http://www.opa.ca.gov/report_card/medicalgroupcounty.aspx](http://www.opa.ca.gov/report_card/medicalgroupcounty.aspx)

**Disease Management Programs/Chronic Condition Management/Complex Case Management/Complex Chronic Conditions Case Management Program**

KP has disease management programs available to help empower individuals with chronic conditions to better understand and manage their disease. Disease management consists of population/care management programs for Members with asthma, diabetes, CAD (coronary artery disease), CHF (congestive heart failure) and chronic pain. In addition, KP has a care management program for Special Needs Members which may include members with multiple and/or complex chronic conditions.
The population/care management programs involve assessing and stratifying the population of Members with specific conditions into smaller subgroups. The subgroups are divided according to their care needs and objectives: “low risk” Members who have well controlled conditions and “higher risk” Members who require additional interventions. Based on the Members’ clinical condition, the Members may be followed in care management to help address their individual care needs.

The Complex Chronic Conditions (CCC) case management program uses nurses and social workers to support Members with multiple chronic conditions and/or high utilization who would benefit from active case management to improve their self-management skills. This program is approximately 2-4 months in duration, depending upon Member needs, and works actively with the Member and their caregivers to achieve defined goals.

Practitioners who have identified KP Members who would benefit from these programs are encouraged to refer them by contacting the relevant care management department at the closest KP facility or by using e-Consult to refer to CCC. Network practitioners can contact the Outside Medical Department with CCC referrals.

**Clinical Practice Guidelines (CPG)**

KP supports the development and use of evidence-based CPGs and Practice Resources to aid clinicians and Members in the selection of the best prevention, screening, diagnostic, and treatment options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. Available CPGs include those for key preventive and non-preventive acute and chronic medical conditions. They provide recommendations for the preferred course of action, while recognizing the role of clinical judgment and informed decision making in determining exceptions. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are distributed to practitioners and are available on two internal Kaiser Permanente intranet websites. Requests for copies of guidelines can be made by calling (510) 625-6343 or by email to clinical.guidelines@kp.org.

**Medical Records (MR) Standards**

KP has developed standards for the content, confidentiality, and security of a Member’s medical records in accordance with HIPAA and California law/regulation. KP MR and office site review standards are generally accepted throughout the medical community and are designed to comply with NCQA and other regulatory requirements.

**Confidentiality of Information**

- Safeguarding medical information is basic to the provision of quality health care. Medical records should be maintained, stored, destroyed and disposed of in a manner that preserves the confidentiality of the information.
- Medical records are stored securely.
- Only authorized personnel have access to records.
- Staff receives periodic training in Member information confidentiality.
- All information communicated in the course of providing care is confidential.
- Release of medical information, which includes all Member identifiable patient information, is to be in compliance with state and federal law and with KPNC and facility guidelines.
- Procedures and standards are in place to maintain patient confidentiality. In addition to the standards that require KP to protect privacy and security of identifiable health information, Health Insurance Portability and Accountability Act (HIPAA) also provides standards for Electronic Date Interchange (EDI) and National Provider Identification (NPI) numbers.
Record Keeping System Requirements

- Electronic capture and storage of PHI may be implemented to enhance access to patient data by health care practitioners and other authorized users.
- Electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the physician office record.
- If any record contains PHI, it is subject to state and federal privacy laws and those records may only be released in compliance with applicable privacy law. KPNC Release of Information polices and procedures shall be followed.
- The safety and security of the physician office record shall be protected at all times in accordance with state and federal regulations.

Medical records are required to be:
- organized and stored in a manner that allows easy retrieval and in a secure manner that allows access by authorized personal only,
- reasonably available at each Member visit, whether in hard copy or electronic format,
- compliant with the KP policies and procedures and applicable regulatory requirements,
- uniform in content and format,
- organized systematically in a way that facilitates data retrieval and compilation.

Entries/Documentation entered into the medical record must be:
- accurate, legible, and complete,
- authored by authorized practitioners and authorship of entries must be clearly identified in the documentation,
- completed at the time the documented services are performed,
- dated and signed,
- unobliterated or unaltered. Documentation errors must be corrected according to established policy and procedure.
- unchanged by the Member. Changes to original documentation in the physician office should be processed according to established state law and local policy and procedure. KPNC Release of Information policies regarding Amendments and/or Corrections shall be followed.

Medical Record Documentation Standards

Each medical record must include the following:
- List of allergies and adverse effects
- Identification of author for each entry
- Date identified for each entry
- Documentation that supports diagnoses
- Legible entries
- Members’ personal biographical data: name, physician office record number, date of birth, age, sex, marital status, address and telephone numbers
- MRN and patient’s name on each page and screen
- Notation of family and social history when pertinent to the presenting problem
- Follow up visit return information noted in days, weeks, or months, or as needed
- List of medications
- Past medical history, surgeries, serious accidents, operations, and illnesses; History and physicals. For child or adolescent <18 yr, PMH inc. sig. prenatal and birth events, operations, immunization and childhood illnesses, and growth charts (if related to encounter)
- Problem list notes including subjective (Hx) and objective (Exam) info pert. to pts presenting C/O
- Documentation of procedures and services performed during visit
- Treatment plans consistent with diagnoses, including orders, patient instructions, and follow-up plans
- Status of preventive and risk screening in accordance with KPNC preventive health guidelines
- Use of tobacco products, alcohol and other substances noted for Members > fourteen (14) years
Unresolved problems from previous visits as addressed in subsequent visits
Consultation reports. If the consultant visit or report was not obtained, then an explanation should be noted on the next visit.
Appropriate laboratory and other studies ordered
Review of all consultation, lab and imaging reports with abnormal values noted

Standards for Availability of Medical Records

The Permanente Medical Group (TPMG):
All TPMG practitioners have access to the electronic HealthConnect physician office record systems. Backup systems and processes are in place to ensure that physicians, clinicians and staff have the tools they need to both provide uninterrupted care. Application Availability reports track the availability of physician office record information and the target for Regional availability is 99.9%.

Network Primary Care Physicians (Coastal Health Alliance and Central Valley (CV) Network):
Medical records are organized and stored in a manner that allows easy retrieval and in a manner that allows access only by authorized personnel. If performance for availability of MR falls below the 100% target, follow-up site visits continue until target is met.

Assessment of MR Documentation and Performance Goals:

PCP practices with electronic medical records (EMR) are not audited because EMR systems include built-in templates for documentation and mandatory fields that are reviewed for compliance and approved prior to being loaded in the system, thus ensuring compliance

For practices that do not have an EMR, MR documentation for PCP records is audited by TPMG Quality Department Staff. The MR documentation audit includes at least five randomly selected MR for each PCP. The target for Regional compliance is 95% and corrective action plans are required for all scores not meeting target. At the time of the MR audit TPMG staff review MR policies and provide the audit results with opportunities for improvement.

Accuracy of Medical Records and Member Health and Enrollment Information

KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other local, state and federal governmental agencies and accrediting organizations request. Such data include, but are not limited to: encounter data, payment data, data entered into the medical record, and any other data pertaining to a Member’s health or enrollment.

All data recorded by KP in the medical record and in other systems that store other Member health and enrollment information must be accurate, complete, and truthful.
Patient Centered Medical Home (PCMH) Recognition

In 2015, all Northern California primary care office settings received recognition from NCQA as Patient Centered Medical Homes. This recognition must be renewed by September of 2017. To maintain this recognition, all primary care settings must ensure that they comply with PCMH recognition standards issued by NCQA in 2014. Among other requirements, primary care practitioners must ensure that:

- Comprehensive health assessments are completed and well-documented in the medical record. For example, standards require that the medical record should demonstrate that practitioners:
  - Have identified if a patient has specific communication requirements due to hearing, vision, or cognition issues
  - Have and document discussions with respect to advance care planning
  - Have and document discussions with respect to risky and unhealthy behaviors beyond physical activity and smoking status (e.g. nutrition, oral health, dental care, familial behaviors, risky sexual behaviors, and secondhand smoke exposure)

- Patients who have been identified and placed in care management have care management plans that are placed in the medical record and, per PCMH standard, do the following:
  - Are developed in collaboration with the patient
  - Incorporate patient preferences and functional/lifestyle goals
  - Identify treatment goals
  - Assess and address potential barriers to meeting goals
  - Include a self-management plan
  - Are provided in writing to the patient

- Patients are asked about their use of over-the-counter medications, herbal therapies, and supplements and patient responses are documented in the medical record

This Northern California NCQA Update letter applies to you as a Provider for products offered by Kaiser Permanente Medical Care Program Affiliated Payors, as referenced in your Agreement with a Kaiser Permanente entity.

To the extent provided in your Agreement, if there is a conflict between this letter and your Agreement, the terms of the Agreement will control. The term "Member" as used in this letter refers to currently eligible enrollees of plans offered by Kaiser Permanente Medical Care Program Affiliated Payors, including Kaiser Foundation Health Plan, and their beneficiaries. The term “Provider” as used in this letter refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement. Additionally, “you” or “your” in the letter refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement and “we” or “our” in the letter refers to Kaiser Permanente. Capitalized terms used in this letter may be defined within the letter or if not defined herein, will have the meanings given to them in your Agreement.