Colorado Children's Health Insurance Program
Child Health Plan *Plus* (CHP+)

FY 2012–2013 Site Review Report

for

Kaiser Permanente Colorado

March 2013

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy and Financing.

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Overview of FY 2012–2013 Compliance Monitoring Activities

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine readiness to comply with federal managed care regulations. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).* Appendix D contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

Objective of the Site Review

The objective of the site review was to provide meaningful information to the Department and the health plan regarding:

- The health plan's compliance with federal regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the health plan's services related to the areas reviewed.

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Kaiser Permanente Colorado** (**Kaiser**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	9	9	8	1	0	0	89%
IV Member Rights and Protections	5	5	4	1	0	0	80%
VIII Credentialing and Recredentialing	50	49	49	0	0	1	100%
X Quality Assessment and Performance Improvement	11	11	11	0	0	0	100%
Totals	**75**	**74**	**72**	**2**	**0**	**1**	**97%**

Table 1-2 presents the scores for **Kaiser** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	75	75	75	0	0	100%
Recredentialing Record Review	79	78	78	0	0	100%
Totals	**154**	**153**	**153**	**0**	**0**	**100%**

2. Summary of Performance Strengths and Required Actions

for **Kaiser Permanente Colorado**

Overall Summary of Performance

For the four standards reviewed by HSAG, **Kaiser** earned an overall compliance score of 97 percent. **Kaiser**'s strongest performances were in Standard VIII—Credentialing and Recredentialing and Standard X—Quality Assessment and Performance Improvement, both of which earned a compliance score of 100 percent. Although HSAG identified one required action in Standard III—Coordination and Continuity of Care and one in Standard IV—Member Rights and Protections, **Kaiser** demonstrated strong performance overall and an understanding of the federal health care regulations, the Colorado CHP+ contract, and the NCQA Standards and Guidelines for Credentialing.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

Kaiser is an integrated care delivery system that subscribes to the patient centered medical home model for coordination of member services through the primary care physician (PCP). Care coordination for CHP+ members with complex medical, behavioral, or social service needs was facilitated through the Pediatric Case and Care Coordination (PCCC) program, working in partnership with the PCP. Members could access the PCCC through self-referral or PCP referral. **Kaiser** used HealthConnect, its electronic health record (EHR) system, to provide multiple tools for assessing member needs, including a comprehensive intake needs assessment administered following referral to the PCCC program. The needs assessment was designed to guide the development of the care coordination plan. All assessment, treatment plan, and care coordination information was maintained within the HealthConnect system and was available to all professionals involved with the care of the member.

During the on-site visit, **Kaiser** staff members presented three care coordination cases: one 4-year-old who was born prematurely and has autism and multiple developmental delays, referred to PCCC by the PCP; one 2-month-old born with cardiac problems and multiple high-priority medical needs, referred to PCCC by the neonatal intensive care unit; and one 18-year-old with medical problems, obesity, autism, and mental health issues. Case presentations demonstrated extensive hands-on involvement of the PCCC staff in communicating and coordinating needs on behalf of the member and family, including coordination with multiple medical providers, mental health providers, and community agencies and services, as appropriate. Case presentations demonstrated that a comprehensive needs assessment was performed. Care coordination notes and verbal presentation provided evidence of a care coordination plan. The system was designed such that a treatment or coordination plan existed for each problem statement or encounter, although a single consolidated assessment and care coordination plan was not generated in the HealthConnect EHR. Care coordination and treatment plan progress notes documented the member's and family's involvement in the treatment plan. **Kaiser** had mechanisms to ensure each member was assigned to a PCP and allowed access to specialists within the **Kaiser** system without authorization or referral.

The member EHR was a compilation of information from many sources. Accessing the member's multiple needs assessments and care plans required navigating through several layers of the EHR system. HSAG recommended, and **Kaiser** recognized, that care coordinators, providers, and families would benefit from having all essential care coordination information consolidated into a single location within the system.

Summary of Strengths

Kaiser invested in programs and resources to benefit all pediatric patients, which, in turn, enabled services, such as the PCCC program, to be available to the CHP+ population. The specialized experience of the PCCC professional staff appeared to be a significant asset to the members and

providers in coordinating essential services with external agencies, community services, and providers.

The **Kaiser** staff model of an integrated system of care provided for an organization-wide, team-oriented approach. This approach allowed health plan staff to work in partnership with providers and created a unified focus and a singular set of policies, guidelines, and objectives to ensure positive member outcomes. The PCCC team functioned as an extension of the PCP in the hands-on coordination of services for members with complex needs. In addition, medical care was provided to members within full-service medical offices, which facilitated access and coordination between primary care, specialty care, behavioral health care, ancillary services, and specialized programs.

The HealthConnect EHR integrated all demographic, clinical, assessment, and care coordination information for the member and served as the primary communication mechanism regarding member care. The EHR was available to clinicians within all **Kaiser** medical offices, as well as affiliated hospitals and skilled nursing facilities to facilitate coordination of care. In addition, high-volume external providers, such as Children's Hospital, had "read only" remote access to **Kaiser** member records and the capability to scan and electronically transmit information to be integrated into the record.

Summary of Required Actions

Kaiser provided a document, The Integration of Care in **Kaiser** Permanente Colorado Patient Centered Medical Home (PCMH document), which articulated many of the concepts required to be in policies and procedures regarding coordination and continuity of care. The document, however, was a position statement and not distributed with the intent or expectation of policies and procedures. **Kaiser** must translate the information and concepts described in the PCMH document into a written policy and procedure regarding coordination and continuity of care.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

Kaiser notified its members of their rights via the Evidence of Coverage booklet. Providers were notified of member rights via the provider manual. Although **Kaiser** had numerous topic-specific policies and documents that addressed each particular member right, HSAG recommended that **Kaiser** develop an overview policy and procedure that briefly describes all member rights afforded to CHP+ members, and refers the reader to the topic-specific policies for more in-depth description of implementation processes. This would ensure that all CHP+ member rights are addressed in policy.

Summary of Strengths

Kaiser had a clear corporate message that members are the primary focus and at the center of **Kaiser**'s mission. **Kaiser**'s processes were such that member payor sources were transparent and not a part of the electronic medical record or daily work. The Principles of Responsibility document was powerful and articulated **Kaiser**'s vision and commitment to creating positive relationships with members, employees, and providers. The Principles of Responsibility document was used in initial and annual compliance training and readily available on the employee and provider portals.

Summary of Required Actions

The member's right to review and amend medical records was addressed in **Kaiser**'s Amendment of Protected Health Information—Member/Patient Requests policy and procedure. Although provider and member communications informed providers and members of a member's right to review and receive a copy of his or her records, the statement did not include the right to amend or correct the records. **Kaiser** must revise provider and member materials to include the right to amend or correct member medical records. **Kaiser** must also develop or revise applicable policies as well as member and provider materials to include the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

Kaiser presented a well-defined and organized credentialing program that included NCQA-compliant policies and processes. The credentialing and recredentialing files reviewed on-site demonstrated that staff members implemented **Kaiser**'s policies and procedures as written. The credentialing committee meeting minutes were well organized and included necessary details that further demonstrated compliance with policies and procedures. **Kaiser** also provided comprehensive procedures for ongoing monitoring of sanctions, compliance, and adverse events.

Summary of Strengths

Kaiser's record-keeping processes across the credentialing program were meticulous. The credentialing and recredentialing files for individual practitioners as well as organizational providers were well organized. Consistency between records made it easy to find the required elements in each file. Staff members used electronic databases to track assessment of organizational providers.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

Kaiser had a well-defined quality improvement (QI) program structure that included the Pediatric Care Quality Committee (applicable to CHP+) and the Service, Quality, and Resource Management Committee (SQRMC) for QI oversight of all Colorado-based care. There was evidence of active physician and staff participation and commitment in all aspects of the program. The program was ultimately accountable to the national Kaiser Foundation Health Plan, which also provided national resources that can be accessed by **Kaiser** Colorado. The QI program consisted of comprehensive monitoring and review processes that addressed underutilization and overutilization, included focus studies, monitored member satisfaction data, review of ongoing performance measures (Healthcare Effectiveness Data and Information Set [HEDIS®][*]), review of grievance data and quality of care concerns, and specified corrective action plans when appropriate. **Kaiser** adopted clinical practice guidelines (CPGs) for all required conditions. CPGs were based on professional, evidence-based national guidelines and modified locally through a formally defined process. CPGs were disseminated to providers and members via **Kaiser**'s Web site and were integrated into the EHR. CPGs were also integrated into specialized programs, member education, and other operations through a formal accountability process.

Kaiser had a highly developed health information system for collecting, analyzing, and reporting data in support of the QI program. The HealthConnect health information system integrated member-related data, claims/encounter information, treatment record information, and assessments, and applied administrative processes (e.g., risk stratification). Additional data, such as member grievances, membership information, and member services data were maintained in separate databases and could be accessed, analyzed, and reported through user queries. The health information system maintained information on member and provider characteristics.

Because of its contract effective date (July 2012), **Kaiser** had not produced an annual QI evaluation report at the time of the site review (January 2013). HSAG recommended that **Kaiser** develop a format for the annual report and ensure that the annual report addresses the required components.

Summary of Strengths

Kaiser demonstrated excellent physician leadership and participation of pediatric providers in achieving the goals of the QAPI program, including an active Pediatric Care Quality Committee. QI activities included comprehensive and thorough review of QI data, studies, and improvement initiatives by QI oversight committees through a structured review process. Meeting minutes included documentation of analysis, recommendations, and actions for follow-up.

Kaiser had a sophisticated health information system for capturing, compiling, and reporting a wide variety of QI data. **Kaiser** compensated for the relatively small size of its CHP+ population by integrating CHP+ data with the greater pediatric population for more meaningful analysis, yet it retained the ability to segregate the CHP+ data, when appropriate. The QI process was facilitated by

[*] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

provider access to the HealthConnect EHR, which incorporated CPGs and other protocols, dashboard reports, and real-time gap analyses and alerts.

Summary of Required Actions

There were no corrective actions required for this standard.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination with any of a member's other providers of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.7.4.1	QI700 – KPCO PCMH Overall Approach, pp. 1-2 QI500-Accessibility P&P, pp. 1-15 QI501- Accessibility of Services Report, pp. 1, 6, 10, 11 PCMH 1D3 – Continuity Report, pp. 2, 12 QI1012 – 2011 Transition to Other Care, pp. 1-2 RR300 - Special Communication Needs NEW, pp. 1-7 **Description of Process:** Primary Care Physicians are responsible for coordinating member care in our patient-centered medical home model. Kaiser Permanente Health Connect. Each contact with the patient is documented and can be read by any member of the healthcare team with the exception of mental health encounters. Every lab, procedure, primary and specialty visit, radiology, pharmacy, and referral is documented. This insures that the patient is getting the optimal care and service. The Physicians at Kaiser Permanente are provided a weekly dashboard report that shows how much access each physician has on his/her schedule, and a continuity report to measure the percentage of times that patients are being seen by their PCP at Primary Care office visits during regular business hours. Additional reports are also done by clinic, by department, and by the region. Each report is posted on the Kaiser Permanente Colorado Primary Care Website for review. The goal is to continually improve access and continuity of care for our patients. The Pediatric Case and Care Coordination (PCCC) team works with families to improve their ability to care for their children at home, to ascertain that their children receive physical and behavioral therapies necessary to improve function, help coordinate care needs with providers, determine eligibility for community and federal resources, and to improve preventative health services for these vulnerable children.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Kaiser Permanente Colorado (Kaiser) Organizational Structure document stated that medical care is provided to members in full-service medical offices owned and operated by Kaiser. These full-service medical offices consisted of primary care, specialty care, pharmacy, laboratory, and radiology services. The document also stated that HealthConnect, the Kaiser electronic health record (EHR) system, is available to all Kaiser clinicians, as well as affiliated hospitals and skilled nursing facilities, to facilitate coordination of care. The Accessibility of Services policy defined appointment availability standards and monitoring methods used to ensure compliance with the standards. The Continuity of Care report tracked how often a member was seen by his or her primary care physician (PCP), thereby promoting continuity of care. The Transition of Care policy described the responsibility of Kaiser clinical professionals to arrange for referral to alternate care resources for members who no longer have a care benefit within Kaiser. The Integration of Care in Kaiser Permanente Colorado Patient Centered Medical Home (PCMH) document stated that the PCP promotes cohesive coordinated care by integrating diverse services. The document described the multidisciplinary medical home team and the components of care coordination including determining the member's care coordination needs, creating a proactive care plan, exchanging information among participants in the patient's care (especially during care transitions), and coordinating with community resources. During the on-site interview, staff stated that the Integration of Care in Kaiser Permanente Colorado PCMH document is a Kaiser position statement used for educational purposes and is not designated as a formal policy.		
Required Actions: Kaiser must translate the information and concepts of the Integration of Care in Kaiser Permanente Colorado PCMH document into a written policy and procedure to meet the requirement.		
2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and those members who require ancillary, social, or other community services. The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate. *42CFR438.208(b)(2)* Contract: Exhibit A—2.7.4.2, 2.7.4..3..2, 2.7.4.3.3	QI700 – KPCO PCMH Overall Approach, pp. 1-2 QI500-Accessibility P&P, pp. 1,8 QI501- Accessibility of Services Report, pp. 1, 11 QI1012 – 2011 Transition to Other Care P+P, pp. 1-2 PCMH 2C1 – 9 – Comprehensive Health Assessment Documentation, pp. 1-8 Peds Special needs example of V code in problem list with key information 9_2011, p. 1 Early Interventions Colorado Referral Form, p.1 PEDS NICU workflow Peds CCC dept updated 10_2012, p. 1 Kaiser Peds Care Coordination JFK Fragile Infant Webinar 10.25.12, pp. 1-5 2012_04_23_low_income_support, p. 1 2012_07_26_CommunityResources_Flyer_FINAL, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	KPCO Medicaid Care Team contact info 11.12, pp. 1-2 Medicaid discharge wkfl v2 2012, p. 1 2010_03_17_job_aid_bh_care_plan, pp. 1-2 PCMH 4B3 – P&P CRICC BHO Procedures and Workflow, pp. 1-6 Medicaid care coordination behavioral health care project 9.2012, pp. 1-3 PCMH 4B4 – Partners in Health_11_2012, pp. 9, 13-22	

Findings:

Staff stated that the PCP is responsible for coordinating member care. The Kaiser Permanente Colorado Organizational Structure document stated that the PCMH model improves care coordination for members with complex conditions and described the Kaiser Special Needs Plan to provide high-intensity case management and care coordination services to at-risk populations. The Integration of Care in Kaiser Permanente Colorado PCMH document stated that care coordination provided depends on the complexity of needs of each member and that the multidisciplinary medical home team assesses the patient's needs, develops a plan of care, and updates the plan as needed. Care coordination activities were defined as communication with multiple providers and connecting the member with various community resources (financial, social, educational, support). Kaiser submitted several examples of tools used by care coordination staff to accomplish care coordination. Kaiser also provided examples of communications used to inform members of community resources and a brochure describing the Pediatric Case and Care Coordination (PCCC) program.

During the on-site interview, staff described the PCCC program as the unit of professional nurses who support the physicians, members, and families with the coordination of services for members with complex medical or special health care needs. Kaiser physicians, members, and families may refer to the pediatric care coordinator. Staff stated that many CHP+ members with special needs are assisted through the PCCC program. Staff described and provided evidence through case presentations that the pediatric care coordinator assists with service referrals and managing appointments, contacts multiple agencies and schools regarding member needs, and closely monitors members with chronic health conditions or complex acute needs. Staff stated that there are different levels of intensity assigned to members in the care coordination program, as determined by an assessment of member needs.

During the on-site interview, Kaiser presented three care coordination cases: one 4-year-old who was born prematurely and has autism and multiple developmental delays, referred to the PCCC program by the physician; one 2-month-old born with cardiac problems and multiple high-priority medical needs, referred to the PCCC program by the neonatal intensive care unit; and one 18-year-old with medical problems, obesity, autism, and mental health issues. Case presentations demonstrated extensive hands-on involvement of the PCCC staff in communicating and coordinating needs on behalf of the member and family, including coordination with multiple medical providers, mental health providers, and community agencies and services. Staff stated that care coordination is facilitated by the availability of many specialists and special programs (e.g., autism program, wellness counseling) within the Kaiser network. In addition, behavioral health specialists are embedded within Kaiser clinics for patient evaluation and consultation with physicians. Staff

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
stated that the PCCC team includes community resource specialists who assist specifically with community resource referrals. The care coordination process was also facilitated by the integration of pertinent information into the EHR, which can be accessed by the member's health care team. All internal treatment records are recorded in the EHR, as well as the care coordination assessment and care coordinator progress notes. Behavioral health appointments and treatment plans can be monitored, with the exception of protected behavioral health information. Assessments and services from external providers (e.g., Children's Hospital) are transmitted electronically and scanned into the Kaiser member EHR.		
Required Actions: None.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. *42CFR438.208(b)(1)* Contract: Exhibit A—2.5.8.2	ID Card Insert, pp. 1-2 kp.org - PCP information, pp. 1-4 PCMH 1D1 - PCP Linking P&P, p. 1 PCMH 1D2 - PCP Linking Materials, pp. 1-4 WelcomePPSSLetters_autolink , p.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Kaiser Permanente Colorado Organizational Structure document stated that the new member packet includes the member's identified office preference or instructions regarding methods of selecting a PCP. The document stated that a PCP is assigned to the member if one is not selected. Members can receive assistance in selecting a PCP through the Member Services department, the Kaiser Web site, or staff at any Kaiser medical office. Kaiser submitted several examples of member communications that inform members of their assigned PCP (with contact information). Staff stated that the PCP is the designated care coordinator for covered services, and that members with complex needs are often referred to the PCCC program. On-site care coordination case presentations demonstrated that each member had an assigned PCP.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. *42CFR438.208(c)(2)* Contract: Exhibit A—2.7.4.3.1.1	QI700 – KPCO PCMH Overall Approach, pp. 1-2 PCMH 2C1 – 9 – Comprehensive Health Assessment Documentation, pp. 1-8 Prev_Recommendations_Peds, pp. 1-2 2011_11_16_well_cheld_care_health _connect_resources, pp. 1-3 Clinical Guidelines – Development and Behavior Developmental Delay Referral Pathways Clinical Library, p. 1 Health Maintenance Pediatric Clinical Library, p. 1 Peds Special needs example of V code in problem list with key information 9_2011, p. 1 Kaiser Permanente Pediatric Care Coordination Intake documentation11.2012, pp. 1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Integration of Care in Kaiser Permanente Colorado PCMH document stated that care coordination needs are determined based on the member's physical, psychological, and social factors, as well as the patient's health history, functional status, self-management behaviors, and need for support services. The Pediatric Care Coordination Intake document and automated Comprehensive Health Assessment Documentation example provided evidence of the elements of a comprehensive assessment and included all of the required elements. Kaiser submitted numerous examples of clinical guidelines that may be accessed in the EHR system to guide assessment or referrals for members with special needs.

During the on-site interview, staff stated that Kaiser physicians have routine and specialized screening tools readily accessible through the HealthConnect EHR system, and they are often prompted through the EHR with alerts that stimulate assessments. Staff also explained that a comprehensive intake assessment is performed by the pediatric care coordinator (nurse) upon referral to the PCCC program. The assessment is integrated into the EHR, guides the care coordination plan, and is used to assign the level of intensity of care coordination required. Kaiser presented three care coordination cases that demonstrated that a comprehensive needs assessment was performed.

Required Actions:

None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.7.5.2	QI206 – PCP Notification, pp. 1-3 Peds Special needs example of V code in problem list with key information 9_2011, p. 1 Developmental Delay Referral Pathways Clinical Library, p. 1 care_everywhere_request_view, pp. 1-3 PEDS NICU workflow Peds CCC dept updated 10_2012, p. 1 Neuropsychological Testing, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The "care everywhere request view" within the EHR provided evidence of an automated mechanism for Kaiser to request records transfer from other organizations. Kaiser provided examples of instructions for referrals to internal or external services for members with special needs. During the on-site interview, staff explained that many of the types of providers and services needed by members are available within the Kaiser network and that all Kaiser professionals have access to necessary information through the EHR, preventing duplication of services. In addition, external providers are able to access the member EHR remotely through the EPIC system application, thereby allowing direct sharing of member assessments with select, high-volume providers (e.g., Children's Hospital). Staff stated that member needs are also communicated through the care coordinator or the PCP at the time of referral to external providers.		
Required Actions: None.		
6. The Contractor implements procedures to develop an individual treatment plan as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A—2.7.4.3.1.2	QI700 – KPCO PCMH Overall Approach, pp. 1-2 QI1206 – PCP Notification, pp. 1-3 QI1207 – Communication Process with PCMH, pp. 1-11 Peds Special needs example of V code in problem list with key information 9_2011, p. 1 Developmental Delay Referral Pathways Clinical Library, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Integration of Care in Kaiser Permanente Colorado PCMH document stated that care coordination activities include the development of a care plan by the patient, family, and health care team, and outlined the components of the care plan. The Communication Process with PCMH procedure described the protocols for communication between the Complex Case Management (CCM) staff and the PCP, using information in the EHR. On-site presentation of care coordination cases demonstrated that the EHR documented treatment plans based on each assessed need chronologically. Accessing the member's multiple needs assessments and care plans required navigating through several layers of the EHR system. All participating provider notes and clinical interventions were documented in the EHR and could be followed chronologically. Care coordination assessments and progress notes could be accessed through a special tab. Staff stated that physicians may search referrals and select information on demand to identify the		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
overall plan of care, but the EHR system did not have the ability to accumulate information into a consolidated care coordination plan. Staff stated that Kaiser was exploring an electronic capability for a coordinated care plan within the EHR system. HSAG recommended that a consolidated plan of care would be a positive asset and encouraged staff to continue to pursue this capability.		
Required Actions: None.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A—2.7.4.3.1.4	PCMH 2C1 – 9 – Comprehensive Health Assessment Documentation, pp. 1-8 QI400 – KPCO Diversity Demographics, p.1 QI402 – Cultural Analysis Report, pp. 1-4 QI111 – 2012 SQRMC Minutes and Reports, pp. 284, 287-293, 458. October_2012_Written_CLAS_ADDENDUM_SQRMC_10_2012, pp. 1-2. Peds Special needs example of V code in problem list with key information 9_2011, p. 1 Case & Care Coordination Contact & Phone Work flow, pp. 1-2 Developmental Delay Referral Pathways Clinical Library, p. 1 MEM500 Health Plan Services P&P, pp. 2-3, 5 RR405 – KPCO Online Physician and Hospital Directories Policy, pp. 1-5 RR406 – MSD and Facility Directory Screenshots, pp. 1-44 RR300 - Special Communication Needs NEW, pp. 1-7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Comprehensive Health Assessment Documentation document demonstrated that cultural and linguistic and communication needs are included in the assessment. Two of the care coordination case presentations involved members with autism (communication needs), and demonstrated that the members received speech and audiology referrals. The Kaiser Permanente Colorado Organizational Structure document stated that Kaiser members have the ability to make consultation appointments directly with a Kaiser specialty department without a referral from their PCP. Staff stated that patients also have on-site access to behavioral health care specialists in the majority of the Kaiser medical office locations. The Member Services: Health Plan Services policy stated that members may obtain information concerning referrals and authorizations on the Kaiser Web site. The online medical and facility directory allowed member access to contact information on specialty physicians. During the on-site interview, staff stated that PCPs often offer to assist members with referrals.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A—2.7.4.1, 3.1.4.3 (RMHP—3.1.3.3)	RR508 – Email Communications Functions, pp. 1-12 RR509 – Facilities Information Security and Privacy, pp. 1-8 RR510 – Minimum Necessary Policy, pp. 1-6 RR512 – Group Health Plan State, pp. 1-10 RR513 – HIPAA Authorization, pp. 1-11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The HIPAA Authorization policy specified the circumstances in which written member authorization is required for disclosure of protected health information (PHI). The policy stated that authorization is not required for any of Kaiser's own treatment or health care operations or treatment by a third party provider, including case management or care coordination. The policy specifically identified mental health information as protected. The Minimum Necessary policy stated that access, use, and disclosure of PHI is limited to the information required for the intended purpose, and that access to PHI within the work force was restricted based on job categories and the need for the information. The policy stated that Kaiser would restrict access through appropriate physical, administrative, and technical safeguards. Kaiser submitted additional policies that defined specific processes for various safeguards.

During the on-site interview, staff stated that care coordination with mental health professionals may be inhibited by HIPAA and Colorado regulations. However, through the EHR, internal behavioral health appointments and treatment plans can be shared, but not individual behavioral health notes.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A—2.7.4.3.4	Member Resource Guide, pp. 26, 29 RR513 – HIPAA Authorization, pp. 2, 5-6 sep_presentation, pp. 1-17 mrr.kp.org, pp. 1-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Member Resource Guide informed members of their right to participate in medical decisions and included the right to receive all information to decide whether to accept or refuse recommended treatment. The guide stated that members would not receive medical treatment without member or legal guardian consent. The HIPAA Authorization policy stated that member authorization is not required for disclosure of PHI to the individual or family members involved in the member's care. Kaiser submitted evidence of staff training regarding the unique treatment consent issues regarding adolescents.

The on-site presentation of care coordination cases was presented via accessing the HealthConnect system. Notations throughout the EHR demonstrated that the treatment plan and care coordination information was discussed with the member or family. HSAG recommended that Kaiser consider a mechanism to document in the electronic record that the member or family agreed with the proposed treatment plan.

Required Actions:
None.

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	8

Total Score ÷ Total Applicable	=	89%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—3.1.1.1	CHP+ EOC July 2012, p. 37 RR528 - Principles Of Responsibility, p. 6 Member Resource Guide, pp. 29-30 Link to Member Resource Guide, p. 1 No Member Discrimination, pp. 1-2 QI207 - Member Website, pp. 11-15 QI208 - Employee Website, pp. 13-15	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's Principles of Responsibility document articulated Kaiser's commitment to treat members with dignity and respect. The No Discrimination policy articulated Kaiser's commitment to ensure that members are not discriminated against and stated that the Principles of Responsibility guides Kaiser employees in their daily work. Kaiser also had HIPAA compliant policies that addressed privacy and confidentiality of PHI. Kaiser staff members reported that Kaiser employees (including providers) are trained using the Principles of Responsibility at hire and annually. Staff also stated that the Principles document is readily available on Kaiser's Web site, the employee portal, and both the Kaiser provider portal and the community provider portal. Member rights were listed in the CHP+ Evidence of Coverage (EOC) and the Member Resource Guide. Member rights lists were found on the Kaiser Web site under both the member and employee tab. During the on-site interview, Kaiser staff members reported that at enrollment, members receive the EOC, which is revised every year and is based on the line of business and benefit plan. Staff stated that the welcome packet includes a notice informing members how to obtain the member resource guide on Kaiser's Web site. In addition, Kaiser had numerous policies and resources that described how Kaiser complies with the Americans with Disabilities Act (ADA). Although Kaiser had numerous policies and documents that addressed topic-specific member rights, HSAG recommended that Kaiser develop an overview policy that briefly describes all member rights afforded to CHP+ members and refers the reader to the topic-specific policies for more in-depth description of implementation. This would ensure that all CHP+ member rights are addressed in policy.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—3.1.1.1.1	co_providermanual_6_811, pp. 4-6 QI213 - 2012 Affiliated Provider Manual, pp. 182-186 QI214 - 2012 Provider Manual Notification Letter, pp. 1-2 CHP+ EOC July 2012, p. 37	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Colorado Provider Manual (for Kaiser-employed providers) and the Affiliated Provider Manual (for contracted providers) both contained a list of member rights. The Provider Manual Notification letter alerted new affiliated providers of how to locate the provider manual on the Web site. During the on-site interview, Kaiser staff members reported that the Provider Manual Notification Letter is sent annually to affiliated providers. Staff also reported that newly contracted providers are trained within 90 days of contracting to ensure familiarity with the contents of the provider manual, Kaiser's Web sites, and the provider portal.		
Required Actions: None.		
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected.	co_providermanual_6_811, pp. 4-6 QI213 - 2012 Affiliated Provider Manual, pp. 182-186 CHP+ EOC July 2012, p. 37 RR510 - Minimum Necessary Policy, pp. 1-6 RR528 - Principles Of Responsibility, p. 26 Member Resource Guide, pp. 4, 16, 26-30 RR503 - Amendment PHI, pp. 1-7	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—3.1.1.1		
Findings: A list of member rights was found on the employee Web site and in the provider manuals. The Principles of Responsibility described the vision that Kaiser employees treat members with dignity and respect. The Member Resource Guide informed members of their rights, including complaints and appeals and advance directives. None of Kaiser's documents addressed the member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. The right to amend medical records was addressed in Kaiser's Amendment of Protected Health Information Member and Patient Requests policy and procedure. Although provider and member documents informed members and providers of a member's right to review and receive a copy of his or her records, the statement did not include the right to amend or correct the records.		
Required Actions: Kaiser must develop or revise applicable policies as well as member and provider materials to include the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Kaiser must also revise member and provider materials to include the right to amend or correct member medical records.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A—3.1.1.1.7	co_providermanual_6_811, pp. 4-6 QI213 - 2012 Affiliated Provider Manual, pp. 182-186 CHP+ EOC July 2012, p. 37 Member Resource Guide, pp. 25, 56	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The provider manuals described the provider's responsibility to uphold member rights such as providing care without discrimination, and to provide open communication regarding treatment needs and recommendations. The manuals also listed the provider's responsibility to ensure confidentiality of the member's medical record. Member rights were listed in the provider manuals, and members were notified of their rights in both the Member Resource Guide and the CHP+ EOC.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	KPCO ADA Compliance Site_link, p.1 Colorado ADA Compliance PP_link, p. 1 ADA_CO201 ADA Nondiscrimination, p.1 CHP+ EOC July 2012, p. 28 (?) RR528 - Principles Of Responsibility, p. 28 No Member Discrimination, pp. 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Principles of Responsibility included a clear statement that Kaiser does not discriminate on the basis of race, sex, age, education, religion, ancestry, national origin, sexual orientation, gender identity, marital status, or source of payment. The EOC informed members of Kaiser's non-discrimination policies. The ADA Nondiscrimination policy described nondiscrimination requirements under the ADA regulations.

Required Actions:
None.

Results for Standard IV—Member Rights and Protections							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	4

Total Score ÷ Total Applicable	=	80%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	CR106 2012 Purpose of Credentialing - Authority for Credentialing, Pages 1,2, Sec. I., A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser had several policies and procedures that thoroughly described the credentialing and recredentialing processes and demonstrated compliance with NCQA requirements.		
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider). *42CFR438.214(a)* NCQA CR1—Element A1	CR106 2012 Purpose of Credentialing - Authority for Credentialing, Pages 1,2, Sec. I., A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Purpose of Credentialing—Authority for Credentialing policy described each type of practitioner Kaiser credentials. On-site, Kaiser staff members described the relationship between the Kaiser Foundation Health Plan (KFHP) and Kaiser's medical practice group. The KFHP credentials and recredentials practitioners from the Kaiser practice group as well as with contracted providers (primarily specialty providers and organizations). KFHP had a contractual relationship with the medical practice group and with each contracted provider. Kaiser's credentialed providers represented a wide variety of types of practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	CR108 2012 Initial Practitioner Credentialing, Pages 2-4, Sec. I, B. CR109 2012 Practitioner Recredentialing, Pages 2-4, Sec. I, B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Initial Practitioner Credentialing and Practitioner Recredentialing policies both described NCQA-compliant verification sources used for credentialing and recredentialing Kaiser's practitioners.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	CR108 2012 Initial Practitioner Credentialing, Pages 1-2, 2-4, Sec. I. A. & B. CR109 2012 Practitioner Recredentialing, Pages 1-2, 2-4, Sec. I, A &B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policies described the criteria for credentialing and recredentialing practitioners.		
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	CR108 2012 Initial Practitioner Credentialing, Pages 4-5, Sec. I., C. CR109 2012 Practitioner Recredentialing , Pages 4-5, Sec. I. C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Initial Practitioner Credentialing and Practitioner Recredentialing policies described the process for forwarding completed credentialing and recredentialing files to appropriate personnel for approval and recommendation, and the role of the credentialing committee in making credentialing and recredentialing decisions.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	CR108 2012 Initial Practitioner Credentialing, Pages 4-5, Sec. I., C. CR109 2012 Practitioner Recredentialing, Pages 4-5, Sec. I, C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's polices described the criteria for determining which files are clean, which files are eligible for Medical director sign-off, and which files are to be sent to the credentialing committee.		
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	CR108 2012 Initial Practitioner Credentialing, Pages 4-5, Sec. I., C. CR109 2012 Practitioner Recredentialing, Pages 4-5, Sec. I, C. CR110 - Delegated - Non-Delegated, pp. 1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegated-Nondelegated Credentialing policy described procedures for delegating credentialing activities and included a pre-delegation audit, assessment of policies and procedures, required provisions for contracting, and oversight procedures.		
Required Actions: None.		
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	CR106 2012 Purpose of Credentialing - Authority for Credentialing, Pages 4-5, Sec.II, G, 1&2. CR121 Confidentiality & Non-Discrimination Agreement, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Purpose of Credentialing—Authority for Credentialing policy described Kaiser's process for ensuring that credentialing and recredentialing is conducted in a nondiscriminatory manner. Steps included committee member attestation of nondiscrimination (template provided for review), and an annual review of approvals and denials with an annual report to the credentialing committee indicating whether patterns of discrimination were detected. On-site, Kaiser provided an example of the annual nondiscrimination report.		
Required Actions: None.		
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	CR107 2012 Access and Confidentiality of Information, Page 2, Sec. II., A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Confidentiality of Information policy described Kaiser's processes for notifying applicants of discrepancies and working with the applicant to obtain correct information.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	CR108 2012 Initial Practitioner Credentialing, Page 5, Sec. I. D. CR109 2012 Practitioner Recredentialing, Page 5, Sec. I.D.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's credentialing and recredentialing policies stated that applicants are notified of the credentialing committee's decision in writing within 60 calendar days of the decision.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	CR106 2012 Purpose of Credentialing - Authority for Credentialing Page 3, Sec. II, B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Purpose of Credentialing—Authority for Credentialing policy stated that the regional executive medical director and the regional associate medical director are co-chairs of the credentialing committee.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	CR107 2012 Access and Confidentiality of Information, Pages 1-2, Sec. I, A & B; Sec., II., B; and Sec. III, A,B,C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Confidentiality of Information policy described procedures for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Procedures included use of locked file cabinets for maintenance of hard copy information, password protected electronic files, and restricted access based on job category and the need for the information. During the on-site interview, Kaiser staff confirmed the processes for ensuring confidentiality of credentialing and recredentialing information.		
Required Actions: None.		
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	CR127 Reconciliation Process and Summaries, Pages 1-28.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Reconciliation Process and Summaries policy described an annual review of practitioner information in directories and other member materials as compared to the credentialing database using a 5 percent sample. On-site, Kaiser staff stated that the credentialing database is populated from credentialing applications. Then, the data are imported to the master provider database. The policy also described interface between the credentialing database and Kaiser's master provider database. Staff stated that online provider directories and member materials are developed from the master database. Staff also stated that all directories are online and that the welcome packet informs members how to obtain the directory online.		
Required Actions: None.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	CR126 2011 - Colorado Health Care Professional Credentials Application (Initial/Recred), Page 23. CR107 2012 Access and Confidentiality of Information, Page 2, Sec. II., B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's credentialing and recredentialing policies described the process for allowing applicants to review information submitted in support of credentialing and recredentialing applications, upon request. Applicants were informed of this right via the Colorado Health Care Professional Credentials Application (credentialing application).		
Required Actions: None.		
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	CR126 2011 - Colorado Health Care Professional Credentials Application (Initial/Recred), Page 23. CR107 2012 Access and Confidentiality of Information, Page 2, Sec. II., A B C D. CR108 2012 Initial Practitioner Credentialing, Page 6, Sec I.F. CR 109 2012 Practitioner Recredentialing, Page 5, Sec. I. F.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Confidentiality of Information policy addressed the practitioner applicants' right to correct erroneous information. Applicants were informed of this right via the credentialing application.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	CR126 2011 - Colorado Health Care Professional Credentials Application (Initial/Recred), Page 23. CR107 2012 Access and Confidentiality of Information, Page 3, Sec. IV., A, B, C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Confidentiality of Information policy addressed the practitioner applicants' right to receive the status of their credentialing or recredentialing application, upon request. Applicants were informed of this right via the credentialing application.		
Required Actions: None.		
2.P. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	CR126 2011 - Colorado Health Care Professional Credentials Application (Initial/Recred), Page 23. CR107 2012 Access and Confidentiality of Information, Page 3, Sec. IV, A,B,C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Access and Confidentiality of Information policy stated that applicants are informed of their rights under the credentialing program via the credentialing application. The credentialing application contained applicant rights.		
Required Actions: None.		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events.	CR907 2012 Identifying and Responding to Ineligible Individuals and Entities-Policy, Pages 1-6. CR907 2012 Identifying and Responding to Ineligible Individuals and Entities-Policy, Pages 1-6. CR 908 2012 Identifying and Responding to Ineligible Individuals and Entities Procedure to Support Policy, Pages 1-14. CR111 2012 - Ongoing Monitoring Sanctions – Complaints, pages 1-2 CR111 2012 - Ongoing Monitoring Sanctions – Complaints, Pages 1-3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	CR900 2012 – Licensing Board Reports, Pages 1-5. CR111 - Ongoing Monitoring, Page 3. CR902-Ongoing Monitoring of practitioner complaints Pages 1-3, 7-8, 11-12. CR903-Delegated and Non Delegated QA Reports, Pages 1-9, 10-12. CR904-Member Complaints referred to Quality, Pages 3-6. 7202-14 Complaints Referred to the Quality Department from Regional Nurse Screeners, Page 1. 7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Pages 3-7 QI208 Employee Website, Page 170. CR1000 Practitioner Performance Review and Oversight, Pages 13-15, 20. CR902Ongoing Monitoring of Practitioner Complaints, Pages 7-8, 13. CR903 Delegated and Non Delegated QA Reports, Pages 1-12. CR904 Member Complaints referred to Quality, Pages 1-2. CR905 Practitioner Quality file (onsite review). CR906 Regional Semi Annual Complaint Review Process, Pages 1-3. CR902 Ongoing Monitoring of Practitioner Complaints, Pages 7-8 CR903 Delegated and Non Delegated QA reports, Pages 1, 12. CR905 Practitioner Quality file (onsite review). 7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Pages 6-7 CR1000 Practitioner Performance Review and Oversight, Pages 13-15, 20.	

Findings:

Kaiser provided numerous policies, workflow documents, and reports that described processes and provided evidence that Kaiser queried federal and State databases to ensure that Kaiser practitioners and organizational providers have not been excluded from federal health care or other federal program participation. On-site, Kaiser staff members described the process for query of the member complaint database to ensure that complaint information is

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
reviewed at recredentialing. On-site review of credentialing committee meeting minutes demonstrated review of complaint information for the recredentialing decision.		
Required Actions: None.		
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Page 3 CR1000 Practitioner Performance Review and Oversight, Pages 1, 16.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Performance Review and Oversight policy described actions available to Kaiser in cases of inadequate performance or quality of care issues. Actions included peer review of potential quality of care concerns, focused review with resultant improvement plan, oversight of provider practices, immediate action for safety concerns, suspension or termination, and reporting to authorities and appropriate licensing agencies when appropriate.		
Required Actions: None.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Page 3 CR1000 Practitioner Performance Review and Oversight, Pages 1, 16.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy described reporting to the National Practitioner Data Bank (NPDB), and State licensing boards as applicable. Kaiser staff members reported that there had been no instances where providers were reported to authorities for quality of care reasons.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Page 12 2012 Affiliated Provider Manual, Pages 210, 229-235. QI208 Employee Website, Pages 164-169. CR1000 Practitioner Performance Review and Oversight, pp. 14-16 CR1001 Practitioner Appeal Process, pp 1-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The practitioner appeal process was clearly described in the Practitioner Appeal Process policy. The policy included each of the required elements of an appeal process.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	7202-15 Peer Review and Evaluation of Licensed Independent Practitioner Performance, Page 12 QI208 Employee Website, pp. 164-169 QI209 Published Documents, P&P, Page 28. 2012 Affiliated Provider Manual, Pages 210, 229-235. CR1000 Practitioner Performance Review and Oversight, Pages 3-4, 16. CR1001 Practitioner Appeal Process, Pages 1-8. CR1002 Practitioner Notification Letter, Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policy stated that practitioners are informed of provider appeal processes in the letter informing the provider that an adverse action will be taken. Kaiser provided an example of an adverse decision letter. In addition, the policy was found in the provider manual and was available online.		
Required Actions: None.		
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	CR106 2012 Purpose of Credentialing - Authority for Credentialing, Pages 3-5, Sec. II, A-F. CR201 2012 Credentials Committee Roster, Page 1 CR200 2011 Credentials Committee Roster, Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Purpose of Credentialing—Authority for Credentialing policy described the committee processes and membership. Credentialing Committee rosters indicated committee membership representing pediatrics, surgical, and non-physician practitioners as well as administrative personnel. On-site review of credentialing committee meeting minutes demonstrated a range of participating providers.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	CR108 2012 Initial Practitioner Credentialing, Pages 4-5, 9-10, Sec I, C. and Sec II, A-C. CR109 2012 Practitioner Recredentialing, Pages 4-5, 7-8, Sec I, C. and Sec II, A-C. CR108 2012 Initial Practitioner Credentialing, Pages 9-10, Sec. II, A-C. CR109 2012 Practitioner Recredentialing, Pages 7-8, Sec. II, A-C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser staff members reported that all files are sent to the credentialing committee. Clean files are signed at that time by the medical director, and files requiring discussion are reviewed by the committee. Review of credentialing committee meeting minutes demonstrated that Kaiser followed this process.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years).	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B		
Findings: Kaiser's credentialing and recredentialing policies and procedures included NCQA-compliant verification timelines. On-site review of 10 credentialing records and 10 recredentialing records demonstrated that all verification was completed within the required verification timelines.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil), ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Colorado Credentials Application included all the requirements. On-site review of 10 credentialing records and 10 recredentialing records demonstrated that each applicant completed an application that met the requirements.		
Required Actions: None.		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. *42CFR438.610(b)(3)* NCQA CR5—Element A NCQA CR7—Element D	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policies and procedures described using NCQA-compliant primary sources for verification of Medicare/Medicaid or State license sanctions. On-site record review demonstrated that Kaiser queried the required online database at credentialing and recredentialing to confirm that providers did not have sanctions and were eligible for Medicaid program participation.		
Required Actions: None.		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	CR600 Evaluation of KP Practitioner Sites, Pages 2-3, 5-12. CR601 Evaluation of Affiliated Practitioner Sites, Pages 2-3, 5-12. CR 604 Guidelines for Health Records, Pages 1-13. CR 605 Guidelines for Behavioral Health Records, Page 9.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Evaluation of KP Practitioner Sites policy (applicable to Kaiser owned and operated sites) and the Evaluation of Affiliated Practitioner Sites policy (applicable to contracted specialty providers) stated that the threshold for triggering a site visit is three or more complaints in any one category in one month, or one complaint of a severity that would warrant a site visit. The policies also described the automated health record and stated that compliance with health record requirements is continually monitored by the Health Information Systems (HIS) department. The site visit tool was designed such that the same first page (general site information and medical record-keeping) was completed for each provider and subsequent pages were specific to the type of provider. The site visit tool was thorough. During the on-site interview, Kaiser staff reported that the Member Services department produced a monthly report of complaints for the credentialing staff, who then analyzed the information to determine if the threshold for a site visit requirement had been met.		
Required Actions: None.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	CR600 Evaluation of KP Practitioner Sites, Pages 2, 5-12. CR601 Evaluation of Affiliated Practitioner Sites, Pages 2, 5-14. CR602 Semi Annual Complaint Reports, Page 1. CR603 Medical Office Complaints, Page 13. CR600 Evaluation of KP Practitioner Sites, Pages 2, 13-14. CR601 Evaluation of Affiliated Practitioner Sites, Pages 2, 13-14. CR600 Evaluation of KP Practitioner Sites, Pages 3-4, 13-14. CR601 Evaluation of Affiliated Practitioner Sites, Pages 3-4, 13-14. CR603 Medical Office Complaints, Page 13. CR600 Evaluation of KP Practitioner Sites, Pages 3-4, 13-14. CR601 Evaluation of Affiliated Practitioner Sites, Pages 3-4, 13-14. CR602 Semiannual complaint reports, Pages 1, 2. CR603 Medical Office Complaints, Pages 1-12. CR600 Evaluation of KP Practitioner Sites, Pages 3-4, 13-14. CR601 Evaluation of Affiliated Practitioner Sites, Pages 3-4, 13-14. CR603 Medical Office Complaints, Page 13. **NOTE: The Denver/Boulder, Southern Colorado, and Northern Colorado service areas did not have member complaints that met the threshold for a complaint follow up visit.**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Kaiser's policies described conducting follow-up site visits and requiring corrective actions as appropriate until deficient offices meet thresholds. Kaiser staff reported that there had been no site visits based on office site quality during the review period.		
Required Actions: None.		
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policies described the recredentialing process and addressed NCQA-compliant primary sources and timelines. On-site review of 10 recredentialing records demonstrated that all practitioners reviewed were recredentialed within the 36-month time frame.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	CR1100 Evaluation of Affiliated Organizational Provider Care and Service, Pages 2-10, 58-59. CR1102 NTS COE Credentials Validation Policy, Pages 1-3. CR907 Process for Excluded Individuals and Entities, Page 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Process for Excluded Individuals and Entities policy described the procedure to query the Office of Inspector General (OIG) database to ensure eligibility to participate in federal health care programs. The policy also described the procedure to query State regulatory agencies to ensure current State licensure and ensure lack of State sanction activity.		
Required Actions: None.		
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	CR1100 Evaluation of Affiliated Organizational Provider Care and Service , Pages 2, 5-9, 58-59. CR1102 NTS COE Credentials Validation Policy, Pages 1-3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policy addressed confirming whether the organizational provider has been reviewed and approved by an accrediting body. On-site review of five organizational provider records demonstrated that Kaiser obtained accreditation information for organizational providers.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	CR1100 Affiliated Organizational Provider Care and Service, Pages 2, 5-9, 11-59.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policy adequately addressed site visits for non-accredited organizational providers. On-site review of organizational provider records demonstrated that Kaiser followed its procedures. The on-site review of organizational providers included one nonaccredited organization. Kaiser staff members ensured that a site visit had been completed by the Colorado Department of Behavioral Health (DBH); therefore, a Kaiser site visit was not required.		
Required Actions: None.		
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	CR1100 Evaluation of Affiliated Organizational Provider Care and Service , Pages 2, 5-9, 58-59. CR1102 NTS COE Credentials Validation Policy, Pages 1-3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The policy addressed reassessment of organizational providers every three years. On-site record review demonstrated that all organizational providers reviewed were reassessed within the three-year time frame.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Evaluation of Affiliated Organizational Provider Care and Service policy listed acceptable accrediting bodies for each type of organization. Organizational provider records reviewed on-site included accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC), the Accreditation Commission for Health Care (ACHC), the Commission on Accreditation of Rehabilitation Facilities (CARF), and The Joint Commission (TJC).		
Required Actions: None.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	The initial assessment for affiliated organizational providers is prior to contracting by the Network Development and Provider Contracting Department to assure the provider is not excluded from participation in federal or state programs. At re-credentialing, the Regional Compliance department ensures the affiliated providers continue to qualify for participation in federal health care programs by reviewing potential matches identified by National Compliance. The Quality Review Coordinator for the Denver/Boulder, Southern Colorado and Northern Colorado service areas confirm that a provider has been reviewed and approved by an accrediting body at least every three years. State standing is determined by verifying the relevant and current state licensure for each affiliated organization. The National Transplant Services (NTS) assesses and validates the Centers of Excellence (COE) hospitals for initial credentialing and every three years for recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Evaluation of Affiliated Organizational Provider Care and Service policy included the criteria for each type of organizational provider.		
Required Actions: None.		
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	When an organizational provider is not accredited, an on-site quality assessment is conducted. Site review criteria are established to appropriately assess the type of facility being surveyed. A CMS or state site survey or a letter from CMS or applicable State agency which shows the facility was reviewed and indicates it passed inspection may be used in lieu of a Kaiser Permanente survey if it is performed within three years of the initial credentialing date or re-credentialing date and meets Kaiser Permanente standards. Kaiser Permanente may elect to perform a site visit even though the provider is accredited or has a current state site survey.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The site visit tool included evaluation of the credentialing policies and an audit of credentialing records.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard.	The National Transplant Services (NTS) assesses and validates the Centers of Excellence (COE) hospitals for initial credentialing and every three years for recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR11—Element A		
Findings: Kaiser's policies included the provision to accept a State or CMS survey in lieu of performing a site visit. During the on-site interview, Kaiser staff reported that the survey is reviewed and only accepted in lieu of a Kaiser site review if there are no outstanding corrective actions. Staff stated that Kaiser may impose their own corrective action to ensure the issue is closed.		
Required Actions: None.		
15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR11—Element B	CR1100 Evaluation of Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9. CR1102 NTS COE Credentials Validation Policy, pp. 1-3 CR1100 Evaluation of Affiliated Organizational Provider Care and Service, Pages 1-2, 4, 6-9. CR1100 Evaluation of Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9. CR1100 Evaluation of Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policies included assessment of each type of organizational provider. Examples in the on-site record review included a surgical center, a pharmacy, a rehabilitation facility, and a skilled nursing facility.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR11—Element C	CR1100 Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9. CR1100 Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9. CR1100 Affiliated Organizational Provider Care and Service, Pages 1-2, 6-9.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policies included assessment of required behavioral health organizations. One of the organizational provider files reviewed on-site was a community mental health center.		
Required Actions: None.		
17. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR11—Element D	CR1101 Organizational Credentialing Spreadsheet, Pages 1-12. The Affiliated Organizational Provider Credentialing Spreadsheet indicates credentialing and recredentialing dates for all types of providers. Other required information such as accreditation, surveys, sanction checks, state licenses, insurance, quality program, and satisfaction data are included. The information is maintained in an Access database which is updated at the time of each Credentials Committee meeting. Individual organizational provider files include all credentialing/re-credentialing documentation collected for each provider as approved by the Credentials Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organizational provider records demonstrated well-organized, clear documentation of organizational provider assessments.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser delegated credentialing and recredentialing to two provider groups (University Physicians, Incorporated (UPI), and Columbine Medical Group). Kaiser provided evidence on-site of ongoing monitoring and annual audits of both of these physician groups.		
Required Actions: None.		
19. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of the delegation agreement for both delegates demonstrated compliance with this standard.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: During the on-site interview, Kaiser staff reported that, in addition to the delegation agreement, Kaiser had a HIPAA-compliant Business Associate Agreement with each delegate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Both delegation agreements included the required provision that Kaiser retains the right to approve, suspend, or terminate providers. Kaiser provided evidence of reviewing reports from the delegates and maintaining its own records, to ensure having the required information needed to exercise this right.		
Required Actions: None.		
22. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	Evidence available for review on-site	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Not Applicable.		
Required Actions: None.		
23. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site, HSAG reviewed the completed 2011 audit of Columbine Medical Group and evidence that the 2012 audit had been performed (the report was outstanding) as well as the completed 2012 audit of UPI.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's annual audit activities included a review of the delegates' policies and procedures against NCQA standards.		
Required Actions: None.		
25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser provided examples of regular reports submitted by each delegate. On-site, Kaiser staff described the process for review of the reports. Documentation was well organized.		
Required Actions: None.		
26. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	Evidence available for review on-site	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegated/Non-Delegated policy and the delegation agreements described the process for taking corrective action when delegates' performance is inadequate. On-site review of documentation indicated that no corrective actions were required by either delegate in 2011 or 2012.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	49	X	1.00	=	49
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	49	**Total Score**		=	49

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A—2.9	KFHP-CO Organization Structure, pp. 1-13 KPCO Oversight for Integrated Patient Care Quality Program, p. 1 MEM502 – QI Process, pp. 1-6 2012_03_08_pc_regional_goals, p. 1 2012pc_quality _goals_final, pp. 6-82013 Pediatric Quality Goals v.1, pp. 1-2 Ped OGP CHP.ACO WIG draft 1.30.12, p. 1 NutritionPed_2012 Value Profile, pp. 1-4 PCCC and OGP Presentation KP Area Ops 6_2011 On-Boarding Project Charter 20120307, pp. 1-11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
Kaiser staff stated that CHP+ members are included in the overall Kaiser quality improvement (QI) data, monitoring activities, and QI oversight programs. The Kaiser Permanente Colorado Oversight for Integrated Patient Care Quality Program (PCQP) organizational chart delineated the organizational structure of the Kaiser QI program. The chart indicated that the regional Service, Quality, and Resource Management Committee (SQRMC) is accountable of all Kaiser quality management monitoring and oversight activities. The chart also depicted committee reporting structures and oversight roles of the regional medical director, Kaiser Foundation's national Quality and Health Committee, and the national KFHP board of directors. The Kaiser Permanente Colorado Organizational Structure document described the SQRMC responsibilities, including the overall direction and monitoring of QI activities, analyzing and evaluating QI activities, developing quality initiatives, and ensuring follow-up. Kaiser staff members provided several examples of regional QI goals and activities.

During the on-site interview, staff described the role of the Patient Care Quality Committee (PCQC), which reports to the SQRMC, as the QI oversight committee for pediatric care. The PCQC consists of Kaiser physicians and staff who focus specifically on pediatric care processes for all Kaiser lines of business, including CHP+ and Medicaid. The committee reviews all metrics related to pediatric services, with the capability to analyze data by provider group or individual providers. Staff stated that there are six Kaiser clinics that are the primary CHP+ and Medicaid clinics. PCQC meeting minutes documented analysis and action items based on scheduled review functions.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.9.4.4	QI208 - Employee Website, pp. 20-22 MEM800 – Healthplan HT, pp. 1-19 MEM802 – HealthTRAC Suite Profile, p. 1 HealthTRAC HealthViews Product Info Sheet, p. 1 HealthTRAC data flow_8.22.12_rm, pp. Healthviews Screen Shots 12-2012, pp. 1-4 CHP HealthTRAC Outcome Reports, pp. 1-3 OGP Dashboard Report_Q2-2012, p. 7, 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser staff provided several examples of monitoring for underutilization and overutilization of services. Several HealthTRAC information system reports documented the process for identifying gaps in care for specified preventive or chronic care management protocols, resulting in reminders to providers and members about services and interventions due. In addition, the information system produced results related to expected frequency of interventions and utilization of hospital or emergency room (ER) visits for population groups. The quarterly Dashboard Report summarized data related to financial expenditures and inpatient and outpatient utilization measures and trends related to the CHP+ population. During the on-site interview, staff stated that HealthTRAC and Dashboard reports are reviewed by individual physicians, physician leadership, QI staff, and disease management staff. The SQRMC reviews a month-to-month compilation of utilization data, which is reported to the governing board.		
Required Actions: None.		
3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes: ◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period. ◆ The results of member satisfaction surveys completed during the prior 12-month period. ◆ A detailed description of the findings of the program impact analysis.	PCQC PEDS FAQs, p. 1 PCQC Presentation Schedule & Action Plans (open in excel, p. 1, 3) PCQC Medicaid Presentation10.3.2011, pp. 1-15 rpt_pcqd_child_kp_cpmg_region_facilitydept__october 2012_01_00, pp. 1-3 asthma_nov, pp. 1-4 Pediatric Nutrition Services 2012 Scorecard Q2 2012, pp. 1-2 2012 Peds CME handouts (weblink) On-Boarding Project Charter 20120307, pp. 1-11 pt sat meeting notes_09192012, p. 1 2012 Medicaid and CHP+ Pt Sat Report, pp. 1-2 CPMG HR Art of Medicine, p. 1 (weblink) Hispanic Member Engagement_RDCG Meeting_100412, pp. 1-16	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Techniques used by the Contractor to improve performance. ◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period. *42CFR438.240(e)(2)* Contract: Exhibit A—2.9.4.7, 4.7.2.1 (RMHP—4.6.2.1)		
Findings: Kaiser submitted examples of QI reports reviewed over the previous 12-month period, including CHP+ member satisfaction data and results of HEDIS measures. Kaiser submitted evidence of a multifaceted, ongoing performance improvement project (PIP) related to improving engagement of Hispanic members. The SQRMC and PCQC meeting minutes documented review of the submitted examples and many other measures of performance. During the on-site interview, staff stated that the small size of the CHP+ Kaiser enrollment required that the results from many of the quality monitoring measures be combined with all pediatric Medicaid member results in order to have meaningful data, and staff cited that there is a recognized similarity between the needs of Medicaid and CHP+ members. HSAG encouraged staff to continue this analysis approach whenever appropriate. Staff also explained that it is premature to have an annual CHP+ report because the contract for CHP+ became effective July 2012. On-site, HSAG reviewed an annual report of data related to other lines of business in the SQRMC meeting minutes, which incorporated the elements of the requirement. HSAG recommended that Kaiser develop a format for the CHP+ annual report and ensure that the annual report addresses the components specified in the requirements.		
Required Actions: None.		
4. The Contractor shall adopt practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special health care needs. ◆ Well child care. Contract: Exhibit A—2.9.2.1	PCMH 2C1–9–Comprehensive Health Assessment Documentation, pp.1-8 PrenatalServices112010, p. 1 Rooming - OB Clinical Library, pp. 1-6 90389Br2_Issue1_ptrenatal, pp. 1-8 00220534_90217_healthybegin10_postpartum, pp. 1-10 Developmental Delay Referral Pathways Clinical Library, p. 1 Down's Syndrome - routine well child care Clinical Library (weblink) ADHD_diagnosis_treatment, pp. 1-7 prev_recommendations_peds, pp. 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Kaiser staff members provided examples of clinical care guidelines for prenatal and pregnancy care, care of children and adolescents with asthma, care of children with Down's syndrome, attention deficit hyperactivity disorder, and well-child care for children of all ages. During the on-site interview, staff stated that clinical practice guidelines (CPGs) are actively used in the provision of care through the HealthConnect system. All guidelines are available through the HealthConnect system for real-time access as a resource during the treatment of a patient. In addition, well-care and preventive care guidelines are programmed into the EHR to generate gaps in care alerts for each member. Staff demonstrated use of the EHR to guide the practitioner's recommendations during any patient contact. Physicians and staff are trained through monthly medical education programs regarding new or modified CPGs. Staff stated that Kaiser is dedicated to the active use of CPGs in patient care.		
Required Actions: None.		
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A—2.9.2.1.2	QI902 - KPCO Distribution of Guidelines P&P, pp. 2-4 QI903 - Notification of Distribution of Guidelines, pp. 1-11 Pediatric Guidelines 2012, pp. 1-2 Child-Adolescent Asthma Clinical Practice Guidelines, p. 1 Assessment and Treatment of Asthma Tables – Tools, p. 1 interoffice memorandum asthma OGP, pp. 1-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's practice guidelines policy stated that Kaiser CPGs are developed through several local task forces and committees to gain input and consensus of local health care professionals, with oversight of the Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC), which reports to the SQRMC. The primary source for CPGs is the Kaiser national guidelines program, which creates and maintains a core set of CPGs based on evidence-based resources and input from cross-regional Kaiser professionals. National guidelines are posted online in the Kaiser Clinical Library. Kaiser Colorado may modify national guidelines for local use through defined guideline development methodologies. National and regional guidelines are scheduled for update every 2 years. Staff stated that Colorado practice guidelines are monitored and updated annually. Kaiser provided a list of numerous CPGs that were updated in the past 14 months.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
During the on-site interview, staff described the process of adopting clinical guidelines for local use. Local Kaiser department chief physicians work with the national Kaiser Care Management Institute to identify evidence-based guidelines based on national professional sources, which are then reviewed and modified through a formal review process defined by the Care Management Institute. Local physicians may modify the guidelines based on a consensus of local expertise regarding local practice patterns or identified needs that are derived from data-driven review of the Colorado membership. Staff described an example of a pediatric guideline developed in Colorado for treatment of pertussis, which is a particular concern in Colorado.		
Required Action: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.9.2.1.3	Published Documents P&P, pp. 1-4 QI903 - Notification of Distribution of Guidelines, pp. 1-11 Health Connect Provider_Manual_Q3_V2, pp. 87, 96 QI213 - 2012 Affiliated Provider Manual, p.1 QI214 - 2012 Provider Manual Notification Letter, p.1 kp.org_health info and guidelines available to members and community, pp. 1-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Notification of Distribution of Guidelines policy documented e-mail notification to providers regarding new or updated national CPGs available in the online Clinical Library. The Affiliated Provider Manual informed providers of the links to specific guidelines. Kaiser provided evidence that guidelines were also made available to providers through the provider newsletter, through the HealthConnect EHR, and to providers, members, and the public through the Kaiser Web site.		
Required Actions: None.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A—2.9.2.1.4	QI902-KPCO Distribution of Guidelines P&P, pp. 1-4 Resource Stewardship Department Info, pp. 1-2 Well Child Physical 3 year old_intake template from HealthConnect, pp. 1-2 Well Child Info 3 year old_ AVS from HealthConnect, pp. 1-7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Kaiser Permanente Colorado Distribution of Guidelines policy stated that the CKCN/GLC, which oversees Colorado CPG development, includes representatives from pharmacy, information systems, continuing medical education, clinical prevention services, health education, and other areas to which the guidelines may apply. During the on-site interview, staff stated that Kaiser has a formal process for integration of guidelines into various operational areas. Examples included utilization management decisions at the national Kaiser level, member education materials modified to reflect		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
adopted clinical guidelines, disease management processes adapted to incorporate CPG information, and member and provider Web site and newsletter revisions that consider new clinical guidelines.		
Required Actions: None.		
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.9.4.10	HealthTRAC data flow_8.22.12_rm, p.1 Guidelines for Health Records_4322_544, pp. 1-14 Add'l system note: Kaiser Permanente collects and maintains complaint data in Macess EXP, and loads daily call data for Colorado received from a vendor, USAN, into a table loaded within a SQL database. We utilize SQL queries to extract the data and calculate the call statistics. Membership data is entered into "Common Membership", and feeds into HealthConnect, to monitor enrollment and utilization data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser staff stated that the HealthConnect system collects, analyzes, and reports data and serves as the EHR for the Kaiser delivery system. Each contact with the patient is documented and, with the exception of mental health encounters, can be read by any member of the health care team. Every lab, procedure, primary and specialty visit, radiology, pharmacy, and referral is documented. Progress notes and practitioner signatures are also maintained. Paper records from practitioners inside or outside the Kaiser system who do not have access to the HealthConnect system are scanned and incorporated into the EHR. The Guidelines for Health Records policy outlined the documentation and access standards for the patient health record. The HealthTRAC data flow diagram provided a system overview of the data integration of member-related data, claims/encounter information, treatment record information, and assessments, and how the system applied administrative processes (e.g., risk stratification).Staff stated that additional data, such as member grievances, membership information, and Member Services call data are maintained in separate databases, which can be accessed, analyzed, and reported through user queries.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.10.2	Guidelines for Health Records_4322_544, pp. 1-14 HealthTRAC data flow_8.22.12_rm, p.1 Health Connect Provider_Manual_Q3_V2 RR405 - KPCO Online Physician and Hospital Directories Policy, pp. 1-6 RELP Data Discussion_Medicaid & CHP+_20120928, p.1 kp.org - PCP information, pp. 1-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The HealthTRAC Data Flow diagram and the Guidelines for Health Records policy documented that member demographic information, claims information, and all health treatment information is collected in the Kaiser HIS. The Online Physician and Hospital Directories policy specified the type of provider characteristics that are collected regarding Kaiser employed or contracted physicians and hospitals. This information is used in the online provider directory and integrated into treatment records and the credentialing database. During the on-site interview, staff stated that Kaiser does not use the race/language information from the State enrollment files but prefers to collect the information directly from the member through an in-person patient encounter, which explores the member's cultural and language characteristics and assigns a more definitive language preference in the member's EHR. This information is used to statistically project the cultural/language characteristics of the entire member population. Staff stated that Kaiser has determined that this approach provides a more accurate and useful definition of member cultural and language characteristics.		
Required Actions: None.		
10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A—2.9.4.3.2, 2.9.4.3.1	QI208 - Employee Website, pp. 16-19 (QRPS) 2011 Patient Survey Sampling Methodology documentation, pp. 1-4 2012 SQRMC Appeals Report, pp. 1-3 pt sat meeting notes_09192012, p. 1 Status SCC 5.9.12, p. 1-13 CPMG HR Art of Medicine, p. 1 (weblink) RR202 - Complaint Process for Non-Medicare Members NEW, pp. 1-17 OGP Team Agenda 01042012_Q of care complaints, p. 1 2012.OGP.Churn.Analysis, p. 1 2011. Adds v Rejoins, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The 2012 Medicaid and CHP+ Patient Satisfaction Report included results of patient survey questions, which included questions regarding accessibility and adequacy of services. During the on-site interview, staff stated that the small sample size and frequent enrollment turnover of the CHP+ membership compromises the ability to validly assess the CAHPS survey data. Kaiser staff members reviewed member satisfaction survey data from the CHP+ population as a component of the overall pediatric population or in combination with Medicaid member information in order to obtain a large enough sample for useful analysis. Staff stated that member survey results are regularly reviewed by Kaiser physician leadership, the PCQC, and the Business Operations department. The Complaint Process for Non-Medicare Members policy outlined the procedures for processing member grievances and entering results in the grievance tracking system. The policy stated that member grievances are assigned to a category type for tracking purposes. Categories included access, customer service, transitions of care, quality of care, patient safety, and quality of office sites. Staff stated that the number of grievances specific to the CHP+ membership is too small to determine patterns, so the grievance information is combined with the data from the Medicaid population and/or the entire pediatric population for analysis. The PCQC reviews the grievance data for pediatric members. During the on-site interview, staff stated that Kaiser reviews any disenrollments due to member dissatisfaction.		
Required Actions: None.		
11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: Exhibit A—2.9.4.3.5	RR202 - Complaint Process for Non-Medicare Members NEW, pp. 9-10 PCQC Presentation Schedule & Action Plans (open in excel, p. 1, 3) Hispanic Member Engagement_RDCG Meeting_100412, pp. 1-16 Patient Registration Associate (PRA) training on cultural competence, p.1 CPMG HR Art of Medicine, p. 1 (weblink)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Complaint Process for Non-Medicare Members policy stated that complaints are individually investigated and resolved, and tracked within the grievance database. Quality of care concerns are referred to the quality management department for investigation and resolution. Kaiser submitted information pertaining to a focus study titled, “Hispanic Member Engagement and Onboarding,” as an example of corrective action taken as a result of a pattern of dissatisfaction among Hispanic members.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Kaiser Permanente Colorado

Reviewer:	Rachel Henrichs	**Review Period:**	January 1, 2010, through December 31, 2012
Participating Plan Staff Member:	Elaine Gatto	**Date of Review:**	January 9, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	I-1		I-2		I-3		I-4		I-5		I-6		I-7		I-8		I-9		I-10	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	NP		LCSW		MD		LCSW		MD		LCSW		MD		DC		MD		MD	
Application Date	8/24/11		4/6/10		8/1/11		1/11/12		3/16/12		6/30/10		5/23/1		8/11/10		4/16/10		2/23/12	
Specialty	Nurse Practitioner		Social Work		Family Med		Social Work		Family Med		Social Work		Orthopedics		Chiropractic		Internal Med		Ortho Surgery	
Credentialing Date (Committee/Medical Director Approval Date)	12/15/11		5/20/10		12/15/11		3/15/12		5/17/12		8/2/10		6/6/11		10/19/10		7/22/10		5/24/12	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		X		NA		X		NA		X		NA		X		X	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	7		7		8		7		8		7		8		7		8		8	
Point Score	7		7		8		7		8		7		8		7		8		8	
Percentage Score	100%		100%		100%		100%		100%		100%		100%		100%		100%		100%	

Total Record Review Score					**Total Applicable: 75**	**Total Point Score: 75**	**Total Percentage: 100%**

Notes:

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Kaiser Permanente Colorado

Reviewer:	Rachel Henrichs	**Review Period:**	January 1, 2010, through December 31, 2012
Participating Plan Staff Member:	Elaine Gatto	**Date of Review:**	January 9, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10	
Provider ID#	R-1		R-2		R-3		R-4		R-5		R-6		R-7		R-8		R-9		R-10	
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		NP		PsyD		MD		MD		MD		MD		MD		MD		MD	
Application/Attestation Date	1/19/10		5/13/11		2/28/12		11/4/10		6/5/07		12/31/09		4/22/10		10/29/12		2/7/11		12/4/08	
Specialty	Endocrinology		Nurse Practitioner		Psychology		Ophthalmology		Gastro		Plastic Surgery		Endocrinology		Gen Surgery		Gen Surgery		Cardiology	
Last Credentialing/Recredentialing Date	4/26/07		9/10/08		5/4/09		12/3/07		8/11/05		3/5/07		7/26/07		11/2/09		4/7/08		5/8/06	
Recredentialing Date (Committee/Medical Director Approval Date)	4/22/10		8/1/11		4/2/12		11/18/10		8/23/07		2/1/10		7/22/10		11/5/12		3/7/11		4/6/09	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		X		NA		X		X		X		X		X		X		X	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		X		NA		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**8**		**6**		**8**		**8**		**8**		**8**		**8**		**8**		**8**	
Point Score	**8**		**8**		**6**		**8**		**8**		**8**		**8**		**8**		**8**		**8**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	
Total Record Review Score									**Total Applicable: 78**				**Total Point Score: 78**				**Total Percentage: 100%**			

Notes: The provider for record #5 terminated his employment with Kaiser prior to the 2010 recredentialing date.

Appendix C. Site Review Participants for Kaiser Permanente Colorado

Table C-1 lists the participants in the FY 2012–2013 site review of **Kaiser**.

Table C-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
Kaiser Participants	**Title**
Leah Brines	Pediatric Care Coordinator
Sean Casey-King	Other Government Programs (OGP) Business Operations Manager
Lynn Cooper	Compliance Coordinator
Sheri Filak-Taylor	Senior OGP Care Delivery Liaison
Elaine Gatto	Credentialing Program Manager
Jill Jamison, MD	Physician Consultant, Quality
Cynthia Lamb	Nurse Manager, Asthma/COPD Disease Management and Pediatric Chronic Care
Annie Lee	Director, Medicaid, CHP+, and CHC
Chrissy Lereaux	Quality, Risk, Patient Safety
Janet Lucchesi, RN	Director of Quality and Accreditation Oversight
Lori Menicos	Senior Financial Analyst for Medicaid, CHP+, and CHC
Kathy Nylin, RN	Quality Review Coordinator
Susan Pharo, MD	Physician Director for Medicaid and CHP+
Nancy Sonnenfeld	Senior OGP Care Delivery Liaison
Claudie Sogrelo	Quality Review Coordinator
MaryJo Strobel	Director of Clinical Quality
Michelle Scranton	Provider Relations and Contracting
Department Observers	**Title**
Teresa Craig	Contract Manager
Russell Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Kaiser Permanente Colorado

If applicable, the health plan is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the health plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the health plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether: ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2012–2013 Corrective Action Plan *for* Kaiser					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard III—Coordination and Continuity of Care 1. The Contractor has written policies and procedures to ensure timely coordination with any of a member's other providers of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living.	During the on-site interview, staff stated that the Integration of Care in Kaiser Permanente Colorado PCMH document is a Kaiser position statement used for educational purposes and is not designated as a formal policy. Kaiser must translate the information and concepts of the Integration of Care in Kaiser Permanente Colorado PCMH document into a written policy and procedure to meet the requirement.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Kaiser					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard IV—Member Rights and Protections 1. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives,	None of Kaiser's documents addressed the member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Although provider and member documents informed members and providers of a member's right to review and receive a copy of his or her records, the statement did not include the right to amend or correct the records. Kaiser must develop or revise applicable policies as well as member and provider materials to include the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Kaiser must also revise member and provider materials to include the right to amend or correct member medical records.				

Table D-2—FY 2012–2013 Corrective Action Plan *for* Kaiser					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected.					

Table D-2—FY 2012–2013 Corrective Action Plan *for* Kaiser					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210).					

Appendix E. Compliance Monitoring Review Activities

for Kaiser Permanente Colorado

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan's managed care contract with the Department, to develop HSAG's monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements. ◆ HSAG considered the Department responses when determining compliance and analyzing findings.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement and recommendations based on the review findings.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.