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

FY 2013–2014 Site Review Report

for

Kaiser Permanente Colorado

February 2014

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

ACKNOWLEDGMENTS AND COPYRIGHTS

1. Executive Summary
for **Kaiser Permanente Colorado**

Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) 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 federal health care regulations and managed care contract 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two years and trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials 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 2013–2014 and the required template for doing so.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any 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 some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal health care regulations.

Table 1-1 presents the scores for **Kaiser Permanente Colorado** (**Kaiser**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* 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)
I Coverage and Authorization of Services	34	34	31	3	0	0	91%
II Access and Availability	22	22	21	1	0	0	95%
Totals	**56**	**56**	**52**	**4**	**0**	**0**	**93%**

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

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)
Denials	150	78	48	30	72	62%
Totals	**150**	**78**	**48**	**30**	**72**	**62%**

Standard I—Coverage and Authorization of Services

Summary of Findings as Evidence of Compliance

Kaiser provided evidence of monitoring services provided to determine appropriateness of amount, duration, and scope. Methods of monitoring included use of metrics derived from HEDIS measures, CAHPS surveys, and review of a variety of utilization reports including those that may indicate overutilization or underutilization of particular services, such as outpatient and emergency services.

Policies and procedures included:

- On-site review of concurrent authorization requests including processes for discharge planning and processes for case management of members with complex needs.
- Initial and continuing authorization.
- Interrater reliability processes with processes for responding to results below 90 percent.
- Processes to consult with requesting providers and board certified specialists in difficult cases.
- Processes to ensure that individuals with appropriate clinical expertise in treating members' conditions make decisions that deny or limit authorization of requested services.

- The definition of *medical necessity* that was consistent with the contract and federal definitions.
- The process for requesting an extension of the authorization decision time frame, with an extension letter template that included fields to insert the required information.

The on-site record review demonstrated that utilization management (UM) decisions were made by physician reviewers and were based on established criteria. All denial records reviewed contained evidence that written notice of the denial was provided to members and requesting providers. On-site, Kaiser staff members described medical direction of the UM program as local and accomplished through the Service Quality Resource Management (SQRM) committee as well as through the use of physician reviewers who review all potential denials.

Summary of Strengths

On-site review of Kaiser's electronic system used to manage authorizations demonstrated the processes for making authorization decisions, tracking dates, and assigning cases to reviewers with the appropriate expertise based on the service request. The system also demonstrated Kaiser's process to ensure that authorizations are made within the required time frames, and it documented the criteria used for making decisions. The authorization system was linked electronically to the electronic health record (EHR) allowing medical reviewers to search for diagnoses and conditions of record that would justify the service request under review. The EHR and electronic authorization process was used for all Kaiser lines of business.

Kaiser's policies and procedures, as well as member information regarding emergency services and poststabilization services, adequately described processes in compliance with federal regulations. The member resource guide notified members that emergency services are available in- or out-of-network. On-site, Kaiser staff members reported that staff members annually run emergency claims reports that are carefully reviewed to ensure that no emergency claims are inappropriately denied, and that emergency claims are paid per the prudent layperson standard.

Summary of Findings Resulting in Opportunities for Improvement

Although there was no evidence that offering a reconsideration process following the release of the notice of action (NOA) impacted Kaiser's ability to meet authorization decision timelines or appeal resolution requirements, Kaiser should consider reviewing its policies to determine if revision is warranted. Once the NOA is sent, any request from a member or provider acting on behalf of the member must be considered an appeal and be resolved within the time frame for resolving appeals, and a notice of resolution must be sent in writing and include the information required in an appeal resolution notice.

The revised Appeal Rights document that Kaiser planned to use as an attachment to NOAs and as part of the explanation of benefits included information about continuation of benefits, when continuation of benefits (services) may be requested, and the fact that the member may be held liable for the costs of those benefits that were continued during an appeal or State fair hearing. The information in the revised attachment was accurate; however, Kaiser may want to consider clarifying the information by adding that the time frame for filing an appeal with a request for

continued benefits in the case of termination, suspension, or reduction of services is within 10 days, or before the effective date of the action. Kaiser may also want to consider clarifying that the services would continue (in addition to the other continuation time frames listed) until 10 days after the notice of the appeal decision adverse to the member unless the member requests a State fair hearing within those 10 days. Kaiser may also want to clarify that Kaiser may recover the cost of services that were provided during the appeal or State fair hearing if the final decision upholds the original denial (adding "the State fair hearing" to the existing statement).

Summary of Required Actions

Kaiser must ensure that the appeal rights information that accompanies the EOB is accurate and applicable to the CHP+ population and that the EOB reason language is clarified or that the EOB is accompanied by an NOA that includes the required information in easy-to-understand language. Kaiser must also ensure that NOAs (whether using an NOA format or an EOB format) include accurate time frames.

Kaiser must ensure that NOAs for preservice decisions are sent within 10 calendar days of the date of the request for services.

Standard II—Access and Availability

Summary of Findings as Evidence of Compliance

Kaiser used an internal network of provider clinics for primary care and specialty care and supplemented the network with contracted external specialty providers where needed. For purposes of determining adequacy of the network, Kaiser included the CHP+ population in the total pediatric population it serves; therefore, network adequacy calculations were based on total population numbers. Staff members reported that Kaiser uses an independent contractor for access mapping and calculation of network adequacy.

Kaiser's provider network included the specific primary and specialty provider types, as required. On-site, Kaiser staff members described recent initiatives to use more nurse practitioners in the primary care provider (PCP) clinics.

Kaiser had processes regarding direct access to specialty care for members with special health care needs and for direct access to women's health care specialists. Member communications adequately informed members regarding direct access to specialists. Kaiser also had processes for allowing members second opinions and allowing members to use out-of-network services if services are unavailable within the network.

Summary of Strengths

Kaiser had detailed tracking and monitoring mechanisms for ensuring that appointments are offered within the required scheduling time frames. Kaiser staff members also reported that Kaiser uses walk-in slots in addition to scheduling for urgent care needs. Staff members also reported that Kaiser uses separate telephone lines for urgent calls.

For appointments with internal providers, Kaiser uses centralized scheduling. External/contracted providers are informed of scheduling requirements via Kaiser's affiliated provider manual. Kaiser staff members reported that members who have Internet access may make their own appointments online and therefore remain in control of their own access timeliness.

Kaiser's processes of developing registries from EHR information and using the resulting data to develop contact plans and case management lists provide member-specific health care and allow members to receive member-specific preventive care based on needs.

Kaiser provided ample evidence of monitoring provider and member perceptions of health care, including use of data collected through HEDIS and CAHPS processes as well as a myriad of other sources of quality improvement data.

Summary of Findings Resulting in Opportunities for Improvement

While Kaiser had multiple processes that provided evidence of culturally responsive practices (including federally compliant policies and procedures and use of interpreters, language lines, and staff training), Kaiser may want to consider member-specific or community-specific prevention and outreach efforts.

Summary of Required Actions

Kaiser must develop a mechanism to inform CHP+ members of scheduling guidelines.

Comparison of Results

Review of Compliance Scores for All Standards

Figure 2-1 shows the scores for all standards reviewed over the past two years of compliance monitoring. (The Department chose not to assign scores for the FY 2011–2012 site reviews.)

Figure 2-1—Kaiser's Compliance Scores for All Standards

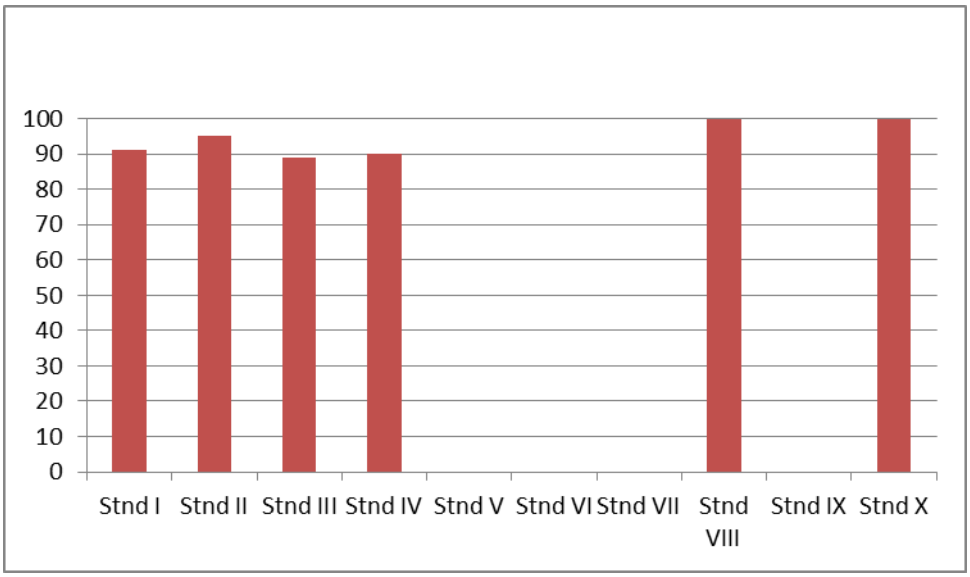


Table 2-1 presents the list of standards by review year.

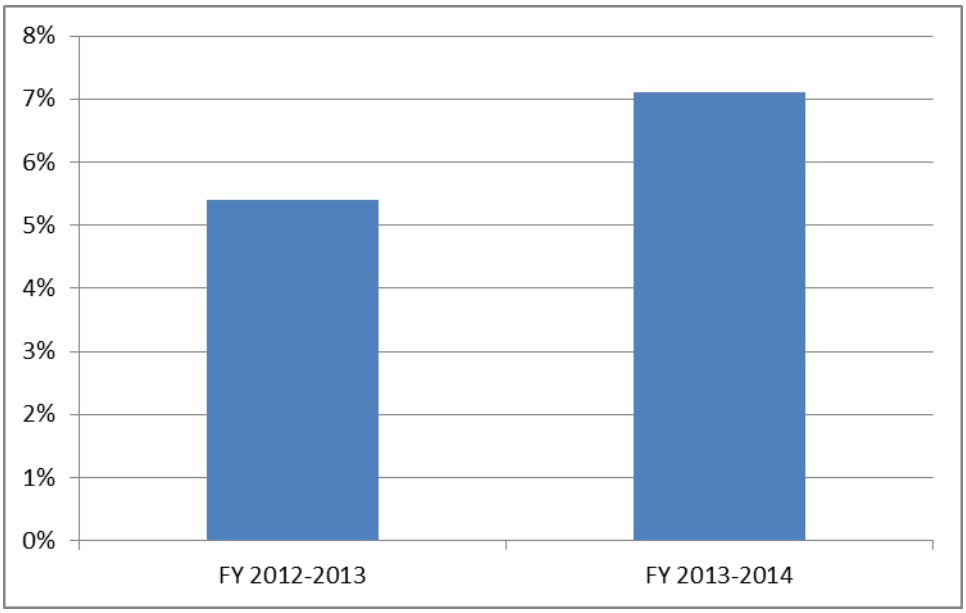
Table 2-1—List of Standards by Review Year			
Standard	**2011–12**	**2012–13**	**2013–14**
I—Coverage and Authorization of Services			X
II—Access and Availability			X
III—Coordination and Continuity of Care		X	
IV—Member Rights and Protections		X	
V—Member Information	X*		
VI—Grievance System	X*		
VII—Provider Participation and Program Integrity	X*		
VIII—Credentialing and Recredentialing		X	
IX—Subcontracts and Delegation	X*		
X—Quality Assessment and Performance Improvement		X	

*These standards were reviewed but were not scored.

Trending the Percentage of Required Actions

Figure 2-2 shows the percentage of requirements that resulted in required actions over the past two years of compliance monitoring. (The Department chose not to assign scores to the CHP+ plans during the FY 2011–2012 site reviews.) Each year represents the results for review of different standards.

Figure 2-2—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements 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 records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials. In addition, HSAG conducted a high-level review of the health plan's authorization processes through a demonstration of the health plan's electronic system used to document and process requests for CHP+ services.

A sample of the health plan's administrative records were reviewed to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG reviewed a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the health plan's services related to the standard areas reviewed.

4. Follow-up on Prior Year's Corrective Action Plan

for **Kaiser Permanente Colorado**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **Kaiser** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

Summary of 2012–2013 Required Actions

As a result of the FY 2012–2013 review, **Kaiser** was required to translate the information and concepts described in the Patient Centered Medical Home (PCMH) document into a written policy and procedure regarding coordination and continuity of care. Also, although **Kaiser**'s 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** was required to revise its provider and member materials to include the right to amend or correct member medical records. **Kaiser** was also required to 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.

Summary of Corrective Action/Document Review

Kaiser submitted its CAP to HSAG and the Department in April 2013. In May 2013, HSAG and the Department requested additional documentation. **Kaiser** submitted the additional documents as they became available. In July 2013, after careful review, HSAG and the Department determined **Kaiser** had successfully implemented its plan and completed all required actions.

Summary of Continued Required Actions

Kaiser has no required actions continued from FY 2012–2013.

Appendix A. Compliance Monitoring Tool for Kaiser Permanente Colorado

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: Amendment 02, Exhibit A-2, 2.6.3 Exhibit K, 1.1	2013 CHP Monitoring Report 2013 CHP ER Monitoring Report These reports demonstrate that the company monitors the services provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor provides the same standard of care for all Members regardless of eligibility category and makes all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-CHP+ Member recipients within the same area. *42CFR438.210(a)(2)* Contract: Amendment 02, Exhibit A-2, 2.6.3.9	Except where required by the CHP+ contract, CHP members receive the same access to services in terms of timeliness, amount, duration and scope as members of other lines of business. **2013 Program Description, Resource Stewardship** Demonstrates all levels of the Utilization Management Program. (see also 2013 KPCO IPCQ PD with Addendum with signatures.pdf, starting on page 430) **Timeliness of UM Decision-Making and Notification, #6891** Demonstrates process for consulting with provider when appropriate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor has a Utilization Management Program that includes: ◆ Prospective, concurrent, and retrospective review ◆ Preauthorization system ◆ Medical Management Team oversight ◆ Transplant coordination ◆ On-site reviews ◆ Discharge planning ◆ Case management	**2013 Program Description, Resource Stewardship** (see also 2013 KPCO IPCQ PD with Addendum with signatures.pdf, starting on page 430) Demonstrates all levels of the Utilization Management Program. **CHP+ KPCP Appropriateness of Care** Resource Stewardship facilitates the delivery of appropriate care and monitors the impact of its UM program to detect and correct potential under- and over-utilization of services. It identifies clinical issues and population need through assessment,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Appeals and grievances ◆ Mechanisms to detect over- and under-utilization Contract: Amendment 02, Exhibit A-2, 2.9.4.4 and Exhibit K, 1.1.1.2	evaluation, and reporting. These standards have been developed based on current standards of medical practice. Appropriate utilization is considered within each CPMG department on an ongoing basis as part of clinical decision making for each patient. Utilization management is monitored through the use of department metrics that track utilization, access, cost, Art of Medicine scores, HEDIS scores and clinical outcomes. **OP2013 CHP+** Outpatient visits rates per thousand CHP+ members per year (HEDIS). This measure summarizes utilization of ambulatory care as outpatient visits. **ER2013 CHP+** Emergency room rates per thousand CHP+ members per year (HEDIS). This measure summarizes utilization of ambulatory care as ED visits. **Referral_authorization_letter Job Aid** Demonstrates step by step processes within the system **7202-108 CHP Member Appeals** Policy describes the CHP Member Appeals program **Additional Documents Submitted On-site:** • Pediatric Care Coordination Work Process • Policy 6891-05—Hospital Admission Authorization and Concurrent Review • Report – Monitoring of Emergency Room Visit Rates Among CHP+ Members – 2013 • Report – Monitoring of Outpatient Visit Rates Among CHP+ Members - 2013	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. Utilization Management shall be conducted under the auspices of a qualified clinician. Contract: Amendment 02, Exhibit A-2, 2.8.1.	**2013 Program Description, Resource Stewardship** (see also 2013 KPCO IPCQ PD with Addendum with signatures.pdf, starting on page 430) (Section III, RS staff) (see also 2013 KPCO IPCQ PD with Addendum with signatures.pdf, starting on page 430) **2013 Resource Stewardship Org Chart**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract: Amendment 02, Exhibit A-2, 2.6.3.10	**Medical Necessity Criteria 13, #6891-14, Policy Statement** Demonstrates the guidelines for utilization management decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* Contract: Amendment 02, Exhibit A-2, 2.6.2 and 2.6.3	**Medical Necessity Criteria 13, #6891-14, Policy Statement** Demonstrates weather limits are applies to services. **Authorization of Services 13, #6891-13, Policy Statement, 2nd page, last paragraph** Document describes information required to make a medical necessity decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State CHP+ program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments. • The ability to achieve age-appropriate growth and development. • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* Contract: Amendment 02, Exhibit A-2, 2.8.1.1 and 1.1.1.56	**Authorization of Services P+P, #6891-13, Policy Statement, 2nd paragraph** Benefits are no more restrictive in amount, duration and scope than that used in the Medicare and State Medicaid program as indicated in state statutes and regulations and the State Plan for Senior Advantage and CHP+ covered persons. **Medical Necessity Criteria P+P, #6891-13, Policy Statement, 1st paragraph** Demonstrates criteria applied to requested services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: Amendment 02, Exhibit A-2, 2.8.1.2	**Authorization of Services P+P, #6891-13, Procedure to implement Policy** Demonstrates process of request to authorize.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**Monitoring of Reviewer Reliability, #6891-15, Policy Statement** Demonstrates how KPCO monitors for consistent decision making. **Additional Documents Submitted On-site:** • 2012 KPCO Interrater Reliability Report	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3	**Authorization of Services P+P, #6891-13, Policy Statement last paragraph** Demonstrates process for consulting with provider when appropriate **Timeliness of UM Decision-Making and Notification, #6891-06, section: Process to implement Policy, Non-urgent care #2** Demonstrates process for consulting with provider when appropriate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has in place and follows written policies and procedures that include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* Contract: Amendment 02, Exhibit A-2, 2.8.1.6 and 2.8.1.3.1	**Authorization of Services P+P, #6891-13, Policy Statement 3rd paragraph** Demonstrates appropriate clinical expertise level in decision making **Denial of Coverage P+P, #6891-12, Policy Statement 3rd paragraph** Demonstrates appropriate clinical expertise level in decision making **Affirmation Statement for Board Certification, #6891-02, Policy Statement** Demonstrates board certification	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.2 and 2.8.1.3.3	**Authorization of Services P+P, #6891-13, Procedure to Implement Policy, #4 section d** Demonstrates notification to member and provider **Denial of Coverage P+P, #6891-12, Policy Statement 4th paragraph** Demonstrates notification to member and provider	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. *42CFR438.210(d)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.B	**Timeliness of UM Decision Making and Notification P+P, #6891-06, Procedure to Implement Policy, 1. Pre-service, b Non-urgent Care, #2 section c and 5. Expedited Determinations for CHP+ covered person, page 7-10** Demonstrates following timelines	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* Contract: Amendment 02, Exhibit A-2, 2.4.3.1.6 10CCR2505—10, Sec 8.209.4.A.1	**Readability Plus Instructions** - Readability Instructions w_Attachments v4.27.11.pdf Kaiser Permanente strives for 6th Grade reading level using the Readability Plus software. The following documents represent notices of action and appeal rights: **CHP Appeal Rights.pdf** **CHP NOA Additional_Info_Letter.pdf** **CHP NOA Benefit Denial Letter with Appeal Rights.pdf** **CHP NOA Med Necessity Denial Letter with Appeal Rights.pdf**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Appeal Rights letter template, used as an attachment to the notice of action (NOA), was easy to understand. Staff reported that Kaiser applies readability software to the template NOA and the Appeal Rights insert and that after member-specific information is inserted in the NOA, UM staff re-read and add text in parenthesis to explain any medical information or language that is not at the sixth-grade level. The Appeal Rights attachment included information about how to obtain the information using a TTY, and in other languages (stated in Spanish, Tagalog, Chinese, and Navajo). Kaiser staff also described the process of using translation vendors, when needed, to ensure communication in members' primary language. The preservice denial in the record review demonstrated use of parentheses to explain difficult-to-understand information. The claims denials reviewed in the record review, however, were difficult to understand. The claims denials used an explanation of benefits (EOB) format as an NOA. The front of the EOB used codes to identify the service denied and the reason for the denial. The code explanations were general and did not clearly describe the situation in easy-to-understand language. In addition, the Appeal Rights information on the reverse side of the EOB contained information that was not applicable to the CHP+ population (appeal processes described were based on the Department of Insurance [DOI] requirements rather than CHP+ requirements) and, therefore, was confusing for the CHP+ population.		
Required Actions: Kaiser must ensure that appeal rights information that accompanies the EOB is accurate and applicable to the CHP+ population and that the reason for the denial is clarified or that the EOB is accompanied by an NOA that includes the required information in easy-to-understand language.		
15. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, authorized representative's, and provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued.	**Denial of Coverage P+P, #6891-Policy Statement, 1. Notice of action for CHP+ covered persons** Description of inclusion of information in the notice of action. The following documents represent notices of action: **CHP NOA Additional_Info_Letter.pdf** **CHP NOA Benefit Denial Letter with Appeal Rights.pdf** **CHP NOA Med Necessity Denial Letter with Appeal Rights.pdf** **Additional Documents Submitted On-site:** • Your Appeal Rights - revised	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42CFR438.404(b)* Contract: Amendment 02, Exhibit A-2, 2.5.5 10CCR2505—10, Sec 8.209.4.A.2		

Findings:

The NOA template submitted for desk review included fields for the action taken and the reason for the action. The Appeal Rights attachment and EOB Appeal Rights information found in the denials record review did not include the current requirements and time frames for filing an appeal or State fair hearing. The attachment used during the review period as well as the appeal rights information on the back of the EOB included inaccurate time frames for filing and processing appeals and did not include State fair hearing information. The Appeal Rights attachment submitted for desk review (revision date 10/18/13) included information about how to file an appeal, how to request a State fair hearing, and the time frames associated with each of these options. The attachment also included information about continuation of benefits, when continuation of benefits (services) may be requested, and the fact that the member may be held liable for the costs of benefits that were continued during an appeal or State fair hearing. The information in the revised attachment was accurate; however, Kaiser may want to consider clarifying the information by adding that the time frame for filing an appeal with a request for continued benefits in the case of termination, suspension, or reduction of services, is within 10 days, or before the effective date of the action. Kaiser may also want to consider clarifying that the services would continue (in addition to the other time frames of continuation listed) until 10 days after the notice of the appeal decision adverse to the member ***unless*** the member requests a State fair hearing within those 10 days, and clarifying that Kaiser may recover the cost of services that were provided during the appeal ***or*** State fair hearing if the final decision upholds the original denial. On-site, Kaiser also provided a draft of the language planned to replace the appeal rights language in the EOB. The information in this document was consistent with the revised appeal rights attachment to the NOA; therefore, the same recommendations apply.

Required Actions:

Kaiser must ensure that notices of action (whether using an NOA format or an EOB format for situations in which the regulations require an NOA for claims denials) include each of the required elements and that any time frames listed are accurate for the CHP+ population.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1 10CCR2505—10, Sec 8.209.4.A.3	**Timeliness of UM Decision Making and Notification P+P, #6891-06, Procedure to Implement Policy, 1. Pre-service, b Non-urgent Care, #2 section c and 5. Expedited Determinations for CHP+ covered person, page 7-10** Demonstrates following timelines	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Kaiser's policy and the revised Appeal Rights attachment to the NOA (revised 10/18/13) included the correct time frames for sending an NOA. During the on-site interview, Kaiser staff acknowledged that the CHP+-required time frames had not yet been implemented and that implementation was planned for January 2014. There was one preservice request reviewed in the denials record review. The NOA was sent 22 days from the date of the		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
request. There were no expedited requests or cases that involved the termination, suspension, or reduction of services. Claims denials were sent at the time of decisions affecting the claim.		
Required Actions: Kaiser must ensure that, for standard preservice requests, NOAs are sent within 10 calendar days of the date of the request for services.		
17. The Contactor may extend the authorization decision time frame if the enrollee requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2. 10CCR2505—10, Sec 8.209.4.A.3	**Timeliness of UM Decision Making and Notification P+P, #6891-06, Procedure to Implement Policy, 1. Pre-service, b Non-urgent Care, #2 section c, page 8** Demonstrates following timelines	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)*	**Timeliness of UM Decision Making and Notification P+P, #6891-06, Procedure to Implement Policy, 1. Pre-service, b Non-urgent Care, #2 , page 8** Demonstrates following timelines and notice content.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3 10CCR2505—10, Section 8.209.4.A.3		
19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: Amendment 02, Exhibit A-2, 2.8.1.1	**Denial of Coverage P+P, #6891-12, Policy Statement, 2nd paragraph.** Demonstrates that there is no financial gain for utilization management decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor provides pharmacy medical management. Contract: Amendment 02, Exhibit K, 1.1	**Policy #: 6294-019, Primary Care Clinical Pharmacy Services (PCCPS) and Collaborative Drug Therapy Management (CDTM)** - P-P 6294_019 Pharmacy PCCPS and CDTM edited.pdf The document provided includes the program policy only. Specific protocol appendices will be available on site. This policy describes the following pharmacy medical management programs: - Primary Care Clinical Pharmacy Services (PCCPS) - Collaborative Drug Therapy (CDTM) **Policy #: 6294-016, Dispensing Prescriptions** - P-P 6294_016 Dispensing Prescriptions.pdf Page 12, Evaluation of Prescriptions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This policy addresses the evaluation of a prescription that is done at the outpatient pharmacy when the drug is being dispensed to the member. This addresses oversight of conflicting medications, allergy screening and other point of service drug utilization edits that are typical in a pharmacy.	
21. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions. ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.27	**Coverage of Emergency Services, #6891-03, Policy Statement, 2nd paragraph** Definition of Emergency Medical Condition **Additional Documents Submitted On-site:** • Priority Calls- desk protocol	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.28	Individual Membership Agreement Page 12 Emergency services and access to care are defined.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: Amendment 02, Exhibit A-2,2.6.6.1.4	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor does not require prior authorization for emergency or urgently needed services. *42CFR438.10(f)(6)(viii)(B)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.3	**Coverage of Emergency Services, #6891-03, Policy Statement, 1st paragraph** Demonstrates that emergency services do not require prior authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions.	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.4, 2.6.6.3.1, and 2.6.6.4.1.3		
26. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2.1 and 2.6.6.1.6	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor will be responsible for Emergency Services when: ◆ The member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. ◆ The primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.7	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* Contract: Amendment 02, Exhibit A-2, 2.6.6.1.5	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* Contract: Amendment 02, Exhibit A-2, 1.1.1.67	**Coverage of Emergency Services, #6891-03, Policy Statement, 6th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(c)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.4	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends. *42CFR438.114(c)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.5 and 6	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.8	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.7	**Coverage of Emergency Services, #6891-03, Policy Statement, 5th paragraph** *KPCO pays emergency services are paid without retrospective review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	31

Total Score ÷ Total Applicable	=	91%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: ◆ Appropriate access to certified nurse practitioners and certified nurse midwives. ◆ 1:2000 primary care physician-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. ◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ENT, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. ◆ Physician specialists designated to practice internal medicine, infectious disease, OB/GYN and pediatrics shall be counted as either PCP or physician specialist, but not both. *42CFR438.206(b)(1)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.5, 2.7.1.1.6, and 2.7.1.1.9	**Policy #7204-09 – Practitioner Availability and Sufficiency of Services** - P-P QI404-Availability.pdf Page 2, Section IV This policy identifies how the company evaluates the availability of practitioners and provider performance to the standards. The process through which the company monitors availability is provided. **Practitioner Availability and Sufficiency of Services Report** - 2013 Practitioner Availability Final 11-12-2013.pdf Pages 7, 9 These pages describe the geographic distribution of KP members, including CHP+. Page 13 This page describes the provider ratios, compared to complaint ratios, for different provider types. Page 17-20 Describes how availability information was used to drive changes to the system. Appendices Several maps supporting the geographic location of members in relation to practitioner types. **Additional Documents Submitted On-site:** • KPCO Network Adequacy Report using Medicaid and Medicare Standards, October 2013	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated CHP+ enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CHP+ services. ◆ The numbers of network providers who are not accepting new CHP+ patients. ◆ The geographic location of providers and CHP+ members, considering distance, travel time, the means of transportation ordinarily used by CHP+ members, and whether the location provides physical access for CHP+ members with disabilities. *42CFR438.206(b)(1)(i) through (v)* Contract: Amendment 02, Exhibit A-2, 2.5.10.1	**Practitioner Availability and Sufficiency of Services Report** - 2013 Practitioner Availability Final 11-12-2013.pdf Pages 7, 9 These pages describe the geographic distribution of KP members, including CHP+. Page 13 This page describes the provider ratios, compared to complaint ratios, for different provider types. Page 17-20 Describes how availability information was used to drive changes to the system. Appendices Several maps supporting the geographic location of members in relation to practitioner types. **CHP Membership Distance Calculation Map.pdf** - This document graphically displays a 30-mile radius around Denver/Boulder medical office building and plots CHP+ membership. 99.6% of CHP+ members reside within a 30 miles of a medical office building as of September, 2013. **Facility Panel Status Daily Report** - FacilityPanelStatus_Daily_20131104 Report represents a daily report used to monitor the percent of physician FTE that are available for assigning patients.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available and providers are qualified and willing to contract on reasonable terms. Contract: Amendment 02, Exhibit A-2, 2.7.1.3.1	**2013 Medical Office Buildings Addresses.pdf** - This document displays a map and lists the physical addresses of Denver/Boulder Medical Office Buildings. **CHP Membership Distance Calculation Map.pdf** - This document graphically displays a 30-mile radius around Denver/Boulder medical office building and plots CHP+ membership. 99.6% of CHP+ members reside within a 30 miles of a medical office building as of September, 2013.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor ensures that members have access to an Essential Community Provider, to the extent such services are available: ◆ Within 30 minutes or 30 miles in urban counties. ◆ Within 45 minutes or 45 miles in suburban counties. ◆ Within 90 minutes or 90 miles in rural counties. Contract: Amendment 02, Exhibit A-2, 2.7.1.3.2	Contract Amendment 02, Exhibit A-2, 1.1.1.80 specifies a definition for "Safe Harbor Standard" and requires the Contractor to demonstrate compliance with regulatory standards established by 45 CFR § 156.235 which governs essential community providers. Section 156.235(a)(2) and (b) specifies an alternate standard of compliance with the essential community provider standard specified in Section 156.235(a)(1) that applies to Kaiser Permanente's integrated delivery model. Under the alternate standard, Kaiser must ensure reasonable and timely access for low-income, medically underserved individuals in its service area, in accordance with the Exchange's' network adequacy standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42CFR438.206(b)(2)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.7	**Denver-Boulder Member Resource Guide** - Denver-Boulder Member Resource Guide.pdf Page 6 Specialty Care Describes self-referrals. Members are able to self-refer to specialists. **Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Page 5 Section Specialty Self Referrals Describes female patients' access to OB/GYN services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42CFR438.208(c)(4)* Contract: Amendment 02, Exhibit A-2, 2.7.5.4	**Denver-Boulder Member Resource Guide** - Denver-Boulder Member Resource Guide.pdf Page 6 Specialty Care Members are able to self-refer to specialists. Page 5 Choosing your Primary Care Provider This section describes the process for having a primary care provider assigned. **Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Page 5 This section describes how members can self-refer to a specialist.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: Amendment 02, Exhibit A-2, 2.7.1.1.8	**Denver-Boulder Member Resource Guide** - Denver-Boulder Member Resource Guide.pdf Page 28 Upper right column Members have the right to request a second opinion. **Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Page 5 Member upon request may have a second opinion.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. If the Contractor is unable to provide necessary primary or specialist services to a member in-network, the Contractor must make special arrangements for members to access out-of-network providers for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: Amendment 02, Exhibit A-2, 2.7.1.2.1	**Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Page 5 Describes continuity-of-care arrangements that can be made to retain an out-of-network provider. **Authorizations Policy & Procedure** - P-P 6891-13 Authorization of Services.pdf Page 2 Describes process by which authorizations are reviewed for both contracted and non-contracted providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor works with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: Amendment 02, Exhibit A-2, 2.7.1.2.2.1	**KFHP External Provider Contract Template** This document will be available on site. Page 36 Member costs are determined by plan and do not change if service must be provided under an out-of-network individual case agreement. Document demonstrates payment rates paid to external providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor ensures that members within the service area have access to emergency services on a 24-hour, 7 days-a-week basis. *42CFR438.206(c)(1)(iii)* Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf page 12 Section Emergency and Non-Emergency7, Non-routine care Emergency services are available at all times. There is no prior authorization required.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Contract: Amendment 02, Exhibit A-2, 2.6.3.5	**Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Page 12 Section A Outside our service area Members are covered for Medically necessary out of plan Emergency Services for conditions which arise unexpectedly. **Policy # 6891- 03 Coverage of Emergency Services** - P-P 6891-03 Coverage of Emergency Services.pdf Emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* Contract: Amendment 02, Exhibit A-2, 2.5.1	**Denver-Boulder Member Resource Guide** - Denver-Boulder Member Resource Guide.pdf page 6 Appointments are available from 8 am – 5:45 pm for all members. KP.org provides hours of operations for all clinics.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.1	**Policy 7204-07 – Accessibility of Services** - P-P QI500-Accessibility.pdf Page 4 The urgent care standard for the region is within 24 hours. **2012 Accessibility of Services Report** - 2012 QI501-Accessibililty of Services Provided is the 2012 report, the 2013 report will be available during fieldwork in December. Page 4, Measure #2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provided is the 2012 report, the 2013 report will be available during fieldwork in December. The report provides the urgent care accessibility metric. **Additional Documents Submitted On-site:** 2013 Accessibility of Services Report	
14. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Non-urgent, symptomatic health care is scheduled within two weeks. ◆ Non-emergent, non-urgent care for a medical problem is provided within 30 calendar days. ◆ Non-symptomatic well care physical examinations are scheduled within 4 months. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2–4	**Policy 7204-07 – Accessibility of Services** - P-P QI500-Accessibility.pdf Beginning at page 2, document shows timing requirements for appointments. **Scheduling Timelines Comparison Grid.pdf** Describes the scheduling guidelines between the CHP+ Contract, the Accessibility of Services Policy and Procedure, and the Affiliated Provider Manual. **KFHP External Provider Contract Template** This document will be available on site. Page 10 Contract requires out-of-network providers to follow scheduling guidelines of the program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Diagnosis and treatment of non-emergency, non-urgent mental health condition scheduled within 30 calendar days. ◆ Diagnosis and treatment of a non-emergent, non-urgent substance abuse condition scheduled within 2 weeks. *42CFR438.206(c)(1)(i)* Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.5 and 2.7.1.5.2.6	**Policy 7204-07 – Accessibility of Services** - P-P QI500-Accessibility.pdf Beginning at page 6, document shows timing requirements for behavioral health appointments. **Scheduling Timelines Comparison Grid.pdf** Compares timelines requirements found the CHP+ contract, the Member Resource Guide, and the Accessibility Policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor communicates all scheduling guidelines to participating providers and members. Contract: Amendment 02, Exhibit A-2, 2.7.1.5.4	**Scheduling Timelines Comparison Grid.pdf** Describes the scheduling guidelines between the CHP+ Contract, the Accessibility of Services Policy and Procedure, and the Affiliated Provider Manual. **Affiliated Provider Manual Section 8** - Affiliated Provider Manual – Section 8 – Quality Page 24 Describes the standards, goals, and methods of measurement for appointment scheduling guidelines. **Policy 7204-07 – Accessibility of Services** - P-P QI500-Accessibility.pdf Page 2 Beginning at page 2, document shows timing requirements for appointments.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	KFHP External Provider Contract Template This document will be available on site. Page 10 Contract requires out-of-network providers to follow scheduling guidelines of the program.	
Findings: Contracted providers were informed of scheduling guidelines via the affiliated provider manual. For Kaiser's internal providers, there is central scheduling. Kaiser's Scheduling Guidelines Comparison Grid displayed the scheduling time frame requirements for several lines of business; and during the on-site interview, Kaiser staff reported that this document is available to scheduling staff members. None of the member information materials submitted included scheduling guidelines for members.		
Required Actions: Kaiser must develop a mechanism to inform CHP+ members of scheduling guidelines.		
17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1.1.1, and 2.7.1.5.4	Wait Times FAQ and Reports - Wait Times FAQ Metric Definitions.pdf Page 3 Metric definition for 'rooming guidelines'. Wait Times Reports - Wait Times 2013-09-30 BiWeekly Health Plan Dashboard Dept.pdf - Wait Times 2013-09-30 BiWeekly Health Plan Dashboard Region.pdf - Wait Times 2013-09-30 BiWeekly Health Plan Dashboard Staff.pdf **Additional Documents Submitted On-site:** • Quality Improvement Process on Accuracy of Information (policy 6592-106)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes: ◆ Risk assessment by a member's PCP or other qualified professionals specializing in risk prevention who are part of the Contractor's participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition. ◆ Health education and promotion of wellness programs, including the development of appropriate preventive services for members with a disability to prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health. ◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members. ◆ Procedures to identify priorities and develop guidelines for appropriate preventive services. ◆ Processes to inform and educate participating providers about preventive services, involve participating providers in development of programs, and evaluate the effectiveness of participating providers in providing such services.	These policies incorporate existing long-standing processes into formal policies and procedures. Policies: - **1.1.1 Prevention Immunizations Adult and Pediatric Policy and Procedure** o PPS P-P 1-1-1 Immunization Program.pdf - **1.2.1 Prevention Health Education Policy and Procedure** o PPS P-P 1-2-1 Health Education Program.pdf - **1.3.1 Prevention Nutrition Services Policy and Procedure** o PPS P-P 1-3-1 Nutrition Services.pdf - **1.4.1 Social Determinants of Health** o PPS P-P 1-4-1 Social Determinants of Health.pdf - **2.1.1 Disease Management Asthma Care Coordination Policy and Procedure** o PPS P-P 2-1-1 Asthma Care Coordination Program.pdf - **3.1.1 Care Coordination Pediatric Care Coordination Policy and Procedure** o PPS P-P 3-1-1 Pediatric Chronic Care Program.pdf - **4.1.1 Clinical Library Policy and Procedure** o P-P 4-1-1 Clinical Library.pdf - **4.2.1 Clinical Guideline Policy and Procedure** o P-P 4-2-1 Practice Guidelines.pdf **Risk Assessment for prevention services** KPCO assesses the risk of members in need of preventive services through close collaboration between Primary/Specialty Care and PPS service providers. *See Policies: 1.1.1 (Section 4.1), 1.2.1 (Section 4.3), 1.3.1 (Section 4.1, 4.2), 2.1.1 (Section 4.1, 4.2)* KPCO utilizes health information in shared EMR (HealthConnect)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Amendment 02, Exhibit A-2, 2.7.8.1	to produce registries of at risk populations in need of either in-person, telephonic, or written prevention outreach. *See Policies: 1.1.1 (Section 4.1), 1.2.1 (Section 4.1), 1.3.1 (Section 4.1) 1.4.1 (Section 4.2, 4.3), 2.1.1 (Section 4.1, 4.2), 3.1.1 (Section 4.1, 4.2)* **Health Education and Promotion of Wellness programs** KPCO health education and wellness promotion programs that create customized and general member facing health education material. *See Policies: 1.1.1 (Section 4.4, 4.5), 1.2.1 (Section 4.2, 4.3), 1.3.1 (Section 4.1, 4.2, 4.3), 2.1.1 (Section 4.2), 3.1.1 (Section 4.1, 4.2)* KPCO preventive services for members with a disability to prevent further deterioration, the following programs include members with disability as part of the services they provide and tailor those services to the needs of the member. *See Policies: 1.3.1 (Section 4.1, 4.2, 4.3), 2.1.1 (Section 4.2), 3.1.1 (Section 4.1, 4.2)* **Evaluation of the effectiveness of health prevention services** KPCO maintains clinician co-led oversight of prevention programs that set goals for and evaluate effectiveness of prevention programs. *See Policies: 1.1.1 (Section 5.0), 1.2.1 (Section 5.0), 1.3.1 (Section 5.0), 2.1.1 (Section 5.0), 3.1.1 (Section 4.3)* **Procedures to identify priorities and develop guidelines for appropriate preventive services** Clinical guidelines and priorities are determined by experts in their respective oversight groups (e.g. Diabetes Governance Council). KPCO governs the publication and dissemination of	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	guidelines through oversight and approval by the Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC). *See Policies: 4.2.1 Kaiser Permanente Colorado Clinical Practice Guidelines Policy and Procedure* **Processes to inform and educate participating providers about preventive services** KPCO shares prevention program resources and clinical guidelines with Primary and Specialty providers through the online Clinical Library, CME, KP Intranet, shared EMR (HealthConnect), and written communications *See Policies: 4.1.1 Kaiser Permanente Colorado Clinical Practice Guidelines Policy and Procedure, 1.1.1 (Section 4.3), 1.2.1 (Section 4.2), 1.4.1 (Section 4.1)* KPCO has implemented preventive guideline based decision support tools into shared EMR (HealthConnect) actively used by Primary and Specialty providers at point-of-service to members *See Policies: 1.1.1 (Section 4.1), 2.1.1 (Section 4.1)* Representatives from Primary and/or Specialty care are included in oversight of all prevention services at KPCO *See Policies: 1.1.1 (Section 5.0), 1.2.1 (Section 5.0), 1.3.1 (Section 5.0), 2.1.1 (Section 5.0), 3.1.1 (Section 4.3)* **Additional Documents Submitted On-site:** • Pediatric Care Coordination Work Process	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, • The medical risks associated with the Client population's racial, ethical, and socioeconomic conditions.	**Individual Membership Agreement** - CHP EOC 201C Under 100 FPL.pdf Contact us Page Provides information on TTY numbers for various departments. Page 32 Member Services provides a telephone interpreter to assist members who speak little or no English. Plan Physicians have access to by telephone to interpreters for over 150 languages. All interpretation will be at no Charge to the member. **National CLAS Standards Fact Sheet** - Int NationalCLASStandardsFactSheet.pdf - Int EnhancedNationalCLASStandards.pdf Provided to company employees to promote culturally and linguistically competent care. **Language Identification Card** - Int Language ID Brochure.pdf This allows non English Speaking individuals to point to their language in order for the company employee to provide the appropriate interpreter. **Flyers/Brochures** - Int 20th Ave Interpreter Flyer_Skylin.pdf - Int DB_Contracted SL Interps_102012.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Making available written translation of Contractor materials, including member handbook, correspondence and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that Participating Providers can: • Conduct the appropriate assessment and treatment of non-English-speaking members (including Members with a communication disability), • Promote accessibility and availability of covered services, at no cost to Members. ◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served, ◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services,	- Int DB_Translation Info_8.2010.pdf - Int On-Site Interp Info_5.2010.pdf - Int Safety Alert_LRC_5.2012.pdf - Int TELEPHONE INTERPRETER SERVICES_KP.pdf The company posts and makes available flyers to their employees to promote interpretive services. Policy 6592-005 – Member Experience: Special Communications Needs - ADA Special Communications Needs.pdf Policy describes the requirement for interpretive services and availability for special communications needs. Policy ADA.CO.201 – ADA Non-Discrimination – Members with Disabilities - ADA_CO201 ADA Nondiscrimination Policy describes compliance with ADA and related policies and procedures.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, ◆ Arranging for Covered Services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities, ◆ Providing access to TDD or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services, ◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape. *42CFR438.206(c)(2)* Contract: Amendment 02, Exhibit A-2, 2.7.7.2		
20. The Contractor analyzes and responds to results of the following HEDIS measures: ◆ Well-Child Visits in the First 15 Months of Life ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ◆ Adolescent Well-Care Visits Contract: Amendment 02, Exhibit A-2, 2.9.4.1.2	**2013 HEDIS Report – Final.pdf** Page 25 Report demonstrates rates for these HEDIS measures. **Medicaid and CHP+ 2012 Quality Performance Presentation** - PCQC MCP Presentation 03-05-2013.pdf Presentation to Pediatric Quality Council regarding HEDIS measures. **Pediatric Primary Care Quality Council & Quality Dashboard**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	FAQs - PCQC PEDS FAQs.pdf Describes the PCQC makeup, purpose, and function. **CHP Quality Improvement Work Plan.pdf** Page 1 Document provides example implementation of process improvements as a result of analyzing HEDIS well-child measures.	
21. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, grievance and appeals data, and enrollment and disenrollment information. Contract: Amendment 02, Exhibit A-2, 2.9.4.3.2	**SQRMC Committee Report – Primary Care Operations** - SQRMC Report – Primary Care Ops 2013.pdf Page 3 Report describes several metrics, including member satisfaction, in relation to accessibility and adequacy of services. **CHP Quality Improvement Work Plan.pdf** Document describes how findings are used to drive improvements in care delivery. **2013 NCQA Population Management Outcomes Report** - 2013_ PPS_Pop_Outcomes_Rpt_Final_2013-08.pdf This report demonstrates analysis and response to a separate HEDIS measure. **Case Resolution Survey Template Tracking.pdf** Document gives example template for tracking member satisfaction with the grievance/complaint process. **Member Satisfaction Survey Tool** - Member Satisfaction Survey Tool 051013 in use The survey used by Case Resolution to track satisfaction with the process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. Contract: Amendment 02, Exhibit A-2, 2.9.4.3.5	**CHP Quality Improvement Work Plan.pdf** Document describes steps taken by Kaiser Permanente to implement recent corrective action plan related to access to care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	22	**Total Score**		=	21

Total Score ÷ Total Applicable	=	95%

Appendix B. Record Review Tool *for* Kaiser Permanente Colorado

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Kaiser Permanente of Colorado

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	December 12, 2013
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Linda Birch-Pierce and Caroline Huddle

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	8/29/13	9/11/13	9/12/13	9/18/13	9/19/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	**6**	**5**	**5**	**5**	**5**
Total Compliant Elements	**4**	**3**	**3**	**3**	**3**
Score (Number Compliant / Number Applicable) = %	**67%**	**60%**	**60%**	**60%**	**60%**

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	9/10/13	9/11/13	9/26/13	9/10/13	9/17/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	**5**	**5**	**5**	**5**	**5**
Total Compliant Elements	**4**	**3**	**3**	**3**	**3**
Score (Number Compliant / Number Applicable = %)	**67%**	**60%**	**60%**	**60%**	**60%**

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable

Requirement	File 11	File 12	File 13	File 14	File 15
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	8/14/13	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	9/5/13	9/26/13	7/26/13	9/21/13	9/21/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	22	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	NC	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	NA	C	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	NC	NC	NC
Total Applicable Elements	**6**	**5**	**6**	**5**	**5**
Total Compliant Elements	**3**	**3**	**4**	**3**	**3**
Score (Number Compliant / Number Applicable = %)	**50%**	**60%**	**67%**	**60%**	**60%**

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable

Total Record Review Score	**Total Applicable Elements: 78**	**Total Compliant Elements: 48**	**Total Score: 62%**

Comments:

For claims denials, the explanation of benefits (EOB) was used for the notice of action (NOA). For preservice denials, an appeal rights insert was sent with the NOA. Each of these documents included the same information. These documents had not been updated to reflect BBA/CHP+ contract/8.209 requirements.

For Record #11 (a preservice request), Requirement #10 was scored as NC because the right to a State fair hearing and how to request it, the circumstances under which expedited resolution is available, and information regarding continuation of benefits was missing from the Appeal Rights insert.

For records # 1 through 10 and 12 through 15 (claims denials), Requirement #10 was scored as NC because the right to a State fair hearing and how to request it was missing. Although the circumstances under which expedited resolution is available and information regarding continuation of benefits was not in the EOB, these rights do not apply to claims denials and therefore were not considered for scoring this requirement.

For each record, Requirement # 15 was scored as NC because the information associated with the right to file an appeal was based on the Division of Insurance (DOI) regulations rather than 8.209 requirements. That is, the member was given 180 days to file an appeal (8.209 states 30 days to file) and was told that the appeal would be resolved within 30 calendar days (8.209 requires 10 working days to resolve an appeal). The appeal rights information also indicated that the second level of review would be with the insurance commissioner instead of the State fair hearing and offered four levels of appeals, including filing with Employment Retirement Income Security Act (ERISA).

Record # 11, Requirement # 8 was scored as NC because the member was notified of the authorization decision 22 days following the request for services. This was a preservice denial for authorization of shoe inserts. The request was received 8/14/13 and notification was sent 9/5/13.

Appendix C. Site Review Participants
for Kaiser Permanente Colorado

Table C-1 lists the participants in the FY 2013–2014 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
Rachel Henrichs	Project Coordinator
Kaiser Participants	**Title**
Linda Burch-Pierce	Audit Manager, Compliance
Melissa Cassa	Consultant, Strategic Market Planning
Denise Crum	Administrative Assistant, MCP
Margaret Fitzhugh (telephonic)	Legal Counsel for KP CHP+
Thuyloan Giang	UM Regulatory Coordinator
Ellen Gibson	Accreditation Specialist
Karoline Huettl	UM Regulatory Officer
Sean-Casey King	Manager, MCP Business Operations KP
Annie Lee	Director, Medicaid and Charitable Coverage Programs (MCP)
Janet Lucchesi	Director of Quality and Accreditation
Mark Merrill	UM Regulatory Coordinator
Jane Payton	Resource Stewardship Project Lead
Chara Perez	Compliance Auditor
Kelly Rickaby	Case Resolution Manager
Adam Stauthamer	Project Manager, Population and Prevention Services
Sandra Trujillo-Laisen	Appeals Manager
Department Observers	**Title**
Teresa Craig	CHP+ Contract Manager
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2013–2014 *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 compliance monitoring site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element 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 health care regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* Kaiser		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th grade reading level wherever possible and available in the prevalent non-English language for the service area).	The claims denials reviewed onsite were difficult to understand. Kaiser used an explanation of benefits (EOB) format as the notice of action (NOA). The front of the EOB used codes to identify the service denied and the reason for the denial. The code explanations were general and did not clearly describe the situation in easy-to-understand language. In addition, the Appeal Rights information on the reverse side of the EOB contained information that was not applicable to the CHP+ population (appeal processes described were based on the Department of Insurance [DOI] requirements rather than CHP+ requirements) and, therefore, was confusing for the CHP+ population.	Kaiser must ensure that appeal rights information that accompanies the EOB is accurate and applicable to the CHP+ population and that the reason for the denial is clarified or that the EOB is accompanied by an NOA that includes the required information in easy-to-understand language.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, authorized representative's, and provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested).	The Appeal Rights attachment and EOB Appeal Rights information found in the denials record review did not include the current requirements and time frames for filing an appeal or State fair hearing. The attachment used during the review period as well as the appeal rights information on the back of the EOB included inaccurate time frames for filing and processing appeals and did not include State fair hearing information.	Kaiser must ensure that notices of action (whether using an NOA format or an EOB format for situations in which the regulations require an NOA for claims denials) include each of the required elements and that any time frames listed are accurate for the CHP+ population.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services.	During the on-site interview, Kaiser staff acknowledged that the CHP+-required time frames had not yet been implemented and that implementation was planned for January 2014.	Kaiser must ensure that, for standard preservice requests, NOAs are sent within 10 calendar days of the date of the request for services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
16. The Contractor communicates all scheduling guidelines to participating providers and members.	None of the member information materials submitted included scheduling guidelines for members.	Kaiser must develop a mechanism to inform CHP+ members of scheduling guidelines.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal health care regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site 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. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ 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. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ service denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 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, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ 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.