FY 2014–2015 Site Review Report Executive Summary

for

Kaiser Permanente Colorado

April 2015

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

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545

Phone 602.801.6600 • Fax 602.801.6051

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 healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 fiscal year (FY) 2014–2015 site review activities for the review period of January 1, 2014, through December 31, 2014. 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 four standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across the three-year cycle, as well as trending of required actions. Section 3 describes the background and methodology used for the 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 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 grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2014–2015 and the required template for doing so. Appendix E describes the activities HSAG performed during the compliance monitoring process.

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 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 assigned for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Kaiser Permanente Colorado** (**Kaiser**) for each of the standards. Findings for all requirements 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)
V	Member Information	23	23	12	7	4	0	52%
VI	Grievance System	26	26	17	7	2	0	65%
VII	Provider Participation and Program Integrity	17	16	14	1	1	1	88%
IX	Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals		**71**	**70**	**48**	**15**	**7**	**1**	**69%**

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

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	50	32	16	16	18	50%
Appeals	24	24	18	6	0	75%
Totals	**74**	**56**	**34**	**22**	**18**	**61%**

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

The CHP+ Evidence of Coverage (EOC) provided extensive information to members about every category of benefits (such as hospital services, pharmacy services, durable medical equipment, and chemical dependency), describing coverage; limitations; and related co-pays for each category. **Kaiser** produced five separate EOCs, each customized with the applicable copays associated with the member's specific CHP+ eligibility level. The CHP+ EOC served as the member handbook during the compliance review period of January 1, 2014, through December 31, 2014. Staff members stated that a new CHP+ member handbook was being developed, with anticipated completion in 2015. Staff stated that the new member handbook will be written in easy-to-understand language and incorporate information related to the specific member information requirements. Member enrollment materials were distributed timely, and **Kaiser** had mechanisms in place to ensure that both member notifications for significant changes in benefits and provider terminations and member requests for information were completed within required time frames. Several of the member enrollment communications were available in Spanish. **Kaiser** has a team of people who monitor any changes in member benefits, contract requirements, or legislation that may impact CHP+ members. The CHP+ EOC is updated annually with any significant changes and redistributed to every CHP+ enrollee. The Member Resource Guide was a nicely designed booklet for all **Kaiser** members. It was written in a member-friendly format and in easy-to-understand language. In addition to providing information on how to use and access **Kaiser** services and facilities, the guide provided information to assist members with understanding how to navigate the plan and repeatedly provided contact information for a variety of departments and services. The Member Resource Guide did not serve as the CHP+ member handbook and was not distributed to all CHP+ members.

Kaiser implemented a new Member Connect department in July 2014 as an enhancement to the ongoing functions performed by the Member Services department. Member Connect was designed to provide personal, individualized assistance to members with understanding the benefits of their individual health plan, selecting a primary care provider, and registering for website access. Members were informed of the Member Connect service center through the Quick-Start Guide included with the member identification (ID) card mailing.

Many of the deficiencies noted in the compliance audit had already been identified by **Kaiser** staff, and mechanisms had been initiated to correct or improve the applicable documents and member information.

Summary of Findings Resulting in Opportunities for Improvement

Note: **Kaiser** stated that a new CHP+ member handbook was being developed with anticipated completion in 2015; therefore, all recommendations related to the CHP+ EOC might also be applicable to the proposed alternative CHP+ member handbook. **Kaiser** may use multiple documents to communicate the member handbook information, as long as all component documents are distributed to all CHP+ members on enrollment and on member request.

The Member Resource Guide, the Quick-Start Reference Guide, some aspects of kp.org, and other materials were available in Spanish; but the EOC was not translated into Spanish. Policies and procedures documented the mechanisms for providing translated materials to members upon request, but the EOC (except related to grievances and appeals) and other member materials did not inform members that materials could be requested in other languages. HSAG recommends that **Kaiser** clearly inform members that materials (including the member handbook/EOC) may be obtained in other languages and how to do so. In addition, since Spanish is the prevalent non-English language, **Kaiser** should consider having a Spanish version of the EOC available for immediate dissemination.

Contractors are required to notify members of any significant change in benefits or procedures 30 days before the effective date of the change. **Kaiser** described the process for monitoring and identifying any significant changes in contract requirements to be incorporated in the annual update of the EOC. Procedures for producing and distributing the revised EOC stated that the revisions would be sent to the *vendor* 30 days prior to the July 1 contract renewal date. HSAG recommends that **Kaiser** review this procedure to ensure that the process also allows for notification to the member 30 days prior to the effective date of any changes. In addition, because the EOC includes an extensive amount of information, **Kaiser** may want to consider highlighting any significant changes in some manner.

The EOC explained that plan providers may refer members for in-plan services and referenced the need for authorization of some services. The EOC did not include information about how the utilization management program determines medical necessity, but instructed members to call Member Services with any questions regarding the utilization management program. The Member Resource Guide more specifically described the Resource Stewardship Program (utilization management) with contact numbers for inquiries or to obtain copies of decision criteria. As the Member Resource Guide is not distributed to all CHP+ members, HSAG recommends that **Kaiser** consider incorporating information concerning the Resource Stewardship Program, determinations of medical necessity, and utilization management points of contact into the proposed CHP+ EOC or revised member handbook.

The time frames listed in the Transition of Care policy (last updated 11/2010) for notifying members of provider termination were not compliant with CHP+ requirements; however, during on-site interviews, staff described current operational procedures that were compliant with the requirement to inform members within 15 days of being notified of the provider's termination from the plan. Staff also provided a revised Transition of Care policy (dated 12/2014). The revised Transition of Care policy stated that members will be notified *at least* 15 working days after receipt of the notice of termination. HSAG recommends that **Kaiser** clarify this statement to specify that notice is provided *within* 15 working days after receipt of the notice of termination.

The EOC comprehensively described the grievance and appeal processes; however, much of the information was written in language that far exceeded a 6th grade reading level and may be difficult for the member to understand. In addition, the extensiveness of the information in this section ("Internal Claims and Appeals Procedures, Grievance Procedures, and External Review") may intimidate or discourage the member from filing an appeal. HSAG recommends that **Kaiser** review and revise the grievances and appeals sections of the EOC for compliance with the ease of understanding requirements per 42CFR438.10(b)(1)and (d).

Summary of Required Actions

Note: **Kaiser** stated that a new CHP+ member handbook was being developed with anticipated completion in 2015; therefore, all required actions related to the CHP+ EOC might also be applicable to the proposed alternative CHP+ member handbook. **Kaiser** may use multiple documents to communicate the member handbook information, as long as all component documents are distributed to all CHP+ members on enrollment and on member request.

The CHP+ EOC, which serves as the member handbook, was not written in easy-to-understand language or format. Some sections included information that appeared to be internal policy or legal contract language. In addition, reviewers observed that the extensiveness of information and small font size could be intimidating to members and obscure the member's ability to locate or easily understand the vital information in the document. Neither the EOC nor other materials distributed on enrollment informed the member that written materials were available in alternative formats or how to access them. **Kaiser** must implement mechanisms to ensure that the CHP+ EOC (and/or the alternative CHP+ member handbook) is written in easy-to-understand language—a sixth grade reading level wherever possible—and format. **Kaiser** must also inform members that enrollment materials are available in alternative formats (including large print, Braille, audiotape, and non-English languages) and how to access them.

While **Kaiser** staff reported that the CHP+ EOC is updated and redistributed to members annually, the EOC did not inform members that they may request and obtain information in the member handbook (EOC) at any time. During on-site interviews, staff members confirmed that **Kaiser** also did not send an annual letter or other annual notice informing members that they may request a handbook/EOC at any time. **Kaiser** must implement a mechanism to notify members annually of their right to request and obtain a member handbook/EOC and other written materials specific to 438.10 (f)(6) and (g).

The member rights section of the CHP+ EOC did not include the member's right to:

- Obtain family planning services from any provider in or out of network without referral.
- Receive a copy of his or her medical records, and request that they be amended.
- Exercise his or her rights, without any adverse effect.

Kaiser must include in the CHP+ EOC a complete listing of member rights as outlined in 42CFR438.10(f)(6)(iii).

Although the EOC comprehensively described the grievance and appeal processes, it did not include a complaint form. A member complaint form was available on the kp.org website; however, the website is only accessible to registered users, and the EOC did not refer members to the website to obtain a complaint form. **Kaiser** must include a complaint form in the CHP+ EOC (or alternative CHP+ member handbook) and/or provide a written reference in the handbook to a readily accessible location on the member website.

The CHP+ EOC described the member's right to make advance directives, encouraged members to provide advance directives to their providers, and referred the member to the Advance Directives Guide for more comprehensive information. However, the EOC did not state that complaints

concerning compliance with the advance directives may be filed with the Colorado Department of Public Health and Environment (CDPHE). **Kaiser** must include in the CHP+ EOC a statement informing the member that complaints concerning noncompliance with the advance directive requirements may be filed with the CDPHE.

The CHP+ EOC did not include information regarding how members may obtain family planning services from out-of-network providers. **Kaiser** must address in the CHP+ EOC the extent to which and how members may obtain family planning services from out-of-network providers.

The CHP+ EOC described how after-hours and emergency services may be accessed per 42CFR438.10(f)(6)(viii). However, the EOC also contained a statement that implied that, when inside the service area, members may need to make a decision about obtaining emergency services from an out-of-plan emergency facility. This statement appears to conflict with the requirement that the *member has the right to use any hospital or other setting for emergency care*. The EOC also described an emergency services exclusion for conditions that, "before leaving the Service Area, you knew or should have known you might require Services while outside our Service Area." **Kaiser** must remove or clarify statements in the CHP+ EOC that are in conflict with the requirements specified in42CFR438.10(f)(6)(viii) and must clearly communicate that the member may obtain emergency services from any emergency facility in or out of network without restrictions. **Kaiser** must also ensure that it does not set arbitrary limits on coverage or payment for emergency services if the member believes he or she has an emergency (using the prudent layperson definition).

The CHP+ EOC did not did not define poststabilization services per 42CFR438.114(a) and did not specify that poststabilization is a covered benefit. The Emergency Services section of the EOC explained that **Kaiser** would "decide whether to make arrangements for necessary continued care where you or your child is, or to transfer you or your child to a Plan Facility we designate once you are stabilized." This section also referenced the member's potential liability for payment of (poststabilization) services received after transfer to an in-plan facility was determined possible. **Kaiser** must address or clarify in the CHP+ EOC the poststabilization care rules applicable to members (including the definition of poststabilization services), that **Kaiser** is responsible for poststabilization services, that poststabilization services end when the member is well enough to be discharged or transferred to an in-network provider, and that the member is only financially responsible for applicable copays for poststabilization services—whether in or out of network.

The CHP+ EOC provided extensive information on termination of membership that included numerous inaccuracies related to the CHP+ population including nonpayment of premiums to **Kaiser** (members do not pay premiums to **Kaiser**), **Kaiser**'s ability to disenroll the member (only the Department may disenroll a member from the Contractor's plan), and reasons for termination not compliant with the "termination for cause" reasons included in 2.4.4.3 of the CHP+ contract. **Kaiser** must revise the EOC to accurately describe disenrollment information per the CHP+ contract with the Department. In addition, **Kaiser** must communicate to members that disenrollees who wish to file a grievance are given opportunity to do so and how to access the Department concerning disenrollment.

The CHP+ EOC did not describe **Kaiser**'s consumer advisory committee or address how members will be notified of any change in services or delivery sites. **Kaiser** must include in the CHP+ EOC

additional information pertaining both to how members will be notified of any change in services or service delivery sites and member participation on the Contractor's consumer advisory committee.

The CHP+ EOC included a section pertaining to third-party liability that stated it is the member's responsibility to inform **Kaiser** of potential third-party liability (e.g., auto accident) and to file claims for third-party liability. However, the EOC did not communicate that the member must follow protocols of third-party payor before receiving nonemergency services. In addition, this section of the EOC contained both an extensive technical "contract level" discussion of **Kaiser**'s rights to recover charges associated with third-party liability and terminology such as "subrogation." **Kaiser** must include information in the EOC that describes the member's responsibility to follow any protocols of a liable third-party payor prior to receiving nonemergency services. Since third-party liability information is difficult to understand and may obscure the communication of the member's essential responsibilities as defined in federal requirements, **Kaiser** must review and revise the third-party liability section of the EOC for compliance with the ease of understanding requirements per 42CFR438.10(b)(1)and (d).

Standard VI—Grievance System

Summary of Strengths and Findings as Evidence of Compliance

The **Kaiser** staff model delivery system offered the opportunity for providers to refer members to many in-plan services and specialists without authorization, thereby simplifying utilization management processes and potentially reducing appeals. **Kaiser** had only seven CHP+ appeals for the 2014 review period. Policies and procedures were in place to guide the grievance, appeal, and State fair hearing processes. All grievances and appeals were documented and tracked in the MACESS software system. While **Kaiser** completed grievance reviews within required time frames, members were also offered a second elevated level of review if dissatisfied with the resolution. Grievances related to quality of care concerns or member experiences in a specific clinic or department were referred to those departments for investigation and necessary corrective actions. Grievance staff made an effort to verbally interact with each member about any grievance to fully understand and respond to the member's concerns. Grievance and appeal staff members assisted members with preparing written grievances, appeals, and State fair hearings— including providing access to appeals files and medical record information when requested.

Summary of Findings Resulting in Opportunities for Improvement

Although procedures, systems, and personnel were in place to support grievance and appeal processes largely compliant with 10 CCR 2505-10, Section 8.209, grievance and appeal record review findings indicated that established procedures were not consistently followed. **Kaiser** may want to consider implementing periodic internal monitoring and auditing to confirm that intended procedures are being executed.

The appeals policy stated that the appeals processing time frame begins on the day the member's verbal or written appeal request is received at **Kaiser**. Since this statement does not clearly specify whether the verbal or written request triggers the time frame for processing the appeal, **Kaiser**

should consider clarifying that, when the initial appeal is verbal, the time frame begins on the date of that verbal appeal.

The grievance policy did not specify that grievance staff will provide assistance to the member in expressing a grievance. While on-site interviews confirmed that staff routinely communicated with and assisted members, **Kaiser** may want to add a description in the policy that addresses how **Kaiser** assists members in filing a grievance.

The grievance policy and the grievance resolution letter defined a second-level grievance review process that could be requested if the member was dissatisfied with the initial grievance resolution, and stated that the disposition offered by the second level review would be final. The CHP+ contract specifies that members can contact the Department with unresolved grievances and that the decision of the Department is final. Staff stated that resolution letters to CHP+ members communicated the option for members to request a second level of **Kaiser** review and/or contact the Department. However, three of 10 grievance resolution letters reviewed on-site offered the **Kaiser** second-level review but did not inform the member that he or she could contact the Department. **Kaiser** should both consider clarifying the policy regarding the appropriate process for CHP+ members and ensure that all grievance resolution letters communicate that the member may contact the Department if not satisfied with the disposition of the grievance.

The CHP+ EOC stated that the member may continue services during an appeal or State fair hearing, "if you follow the procedures outlined above in the 'Internal Claims and Appeals Procedures, Grievances Procedures and External Review' section." Due to the importance of the reduced time frame for filing an appeal when the member is requesting continuation of benefits, HSAG recommends that **Kaiser** more explicitly define the timely filing requirements in the "Continuation of Benefits" section of the EOC.

HSAG noted one case during the appeal record reviews that identified several potential opportunities for improvement. The case involved **Kaiser**'s denial of a subcontracted provider's emergency room charges. **Kaiser** denied the charges due to lack of timely filing by the provider. As a result, the subcontracted provider billed the member for the unpaid charges. The member reported (via a letter to **Kaiser**) that the provider had sued and ultimately received a legal judgment against the member. The member appealed to **Kaiser**, stating that the late filing of the claim by the provider was not the member's responsibility, and asked that **Kaiser** resolve the issue with the provider in order to get the judgment against her lifted. The member's appeal was received four months after **Kaiser** mailed the member an explanation of benefits showing the provider's claim had been denied; therefore, **Kaiser** denied the appeal based on it being outside the required 30-day time frame and closed the case.

HSAG recommends that **Kaiser** review this case and examine internal procedures related to the following:

The member's letter to **Kaiser** was asking for assistance with the actions of the subcontracted provider against the member. **Kaiser**'s examination of the member's appeal letter should have identified the following issues:

1. **Kaiser** denied the original provider claim for emergency service charges due to untimely filing. While **Kaiser** has the right to deny a provider claim for untimely filing, the administrative

denial of a claim is not an action for which the member must receive a notice of action. If **Kaiser** had not notified the member of the action, the member's appeal would have been more appropriately interpreted as a grievance and could have been further explored as such rather than being dismissed by **Kaiser** as a member appeal that was not filed within the required time frame. In addition, perhaps **Kaiser**'s appeal processors should also be trained to identify these types of provider compliance concerns and refer them to the appropriate department for follow-up.

2. By regulation (as addressed in Standard VII, # 13 of the compliance monitoring tool) providers may not bill CHP+ members for charges not paid by **Kaiser**. This is stated in **Kaiser**'s Provider Services Agreement, making the actions of this subcontracted provider out of compliance with the agreement. **Kaiser** should have pursued this issue with the provider on the basis of non-compliance with the provider agreement, which could have resolved the problem on behalf of this member.

Summary of Required Actions

The grievance policy stated that a written acknowledgement would be sent to the member within two working days for all *written* grievances. However, 70 percent of grievance records reviewed on-site did not include written acknowledgement to the member. **Kaiser** must implement mechanisms to ensure that all verbal and written grievances are acknowledged in writing within two working days of receipt of the grievance.

The grievance policy and the CHP+ EOC stated that a grievance would be resolved in 15 working days. However, five of 10 grievance records reviewed on-site did not include a written notice of resolution sent within the required time frame (four of 10 had no written notice of resolution). **Kaiser** must implement mechanisms to ensure that it sends a written notice of grievance resolution to the member within 15 working days of receipt of the grievance.

The appeals policy stated that standard appeal requests would be acknowledged in two working days. However, two of four appeal records reviewed on-site did not include a written acknowledgement letter to the member within that time frame. **Kaiser** must ensure that a written acknowledgement of a standard appeal is sent to the member within two working days of receiving the appeal.

All four of the appeal records reviewed included resolution letters written in language that was not easy to understand. The letters generally included technical contract or procedural explanations of the reason the appeal was being upheld or overturned. **Kaiser** must ensure that appeal resolution letters are written in easy-to-understand language, as specified in 42CFR438.10(b)(1).

The *Appeal Rights* enclosure in the appeal resolution letter described how the member may request a State fair hearing and the member's option to continue benefits during the State fair hearing. However, neither the letter nor the *Appeal Rights* enclosure informed members of either how to request continued benefits or the potential liability for the cost of continued benefits. **Kaiser** must ensure that each appeal resolution letter for cases in which the appeal was not resolved wholly in favor of the member includes both information on how the member may request continuation of

benefits during the State fair hearing and the potential liability for the cost of continued benefits should the hearing decision upholds **Kaiser**'s action.

The appeals policy inaccurately stated that the request for a State fair hearing must be filed within 30 calendar days of *the date of appeal decision* and within 10 calendar days *after the health plan mails the appeal decision* "for services or treatment the member is currently receiving." The CHP+ EOC also included the statement, "If your request is about treatment or Service that has been approved before, you or your DCR must make the request for a State fair hearing within ten (10) calendar days…" The time frames for requesting a State fair hearing are based on the date of the original notice of action. In addition, the reduced time frame (within 10 days of the notice of action or before the date of the intended change or termination) for requesting a State fair hearing applies only when the member is requesting continuation of previously authorized benefits. **Kaiser** must clarify policies and member communications to accurately state that the member may request a State fair hearing within 30 calendar days from the date of the notice of action (not the date of the appeal decision) and that the 30-day time frame applies to any action, unless the member is requesting continuation of benefits during the State fair hearing.

Both the appeal policy and the CHP+ EOC included confusing statements regarding the time frame for notifying the member of a denial of a request for an expedited appeal. The Appeals policy stated that, "Appellant will be notified…in writing within two calendar days of the *verbal notification* not to expedite the Appeal," and the EOC stated that the health plan will give oral notice within two *working* days of receipt of appeal and send written notice. **Kaiser** must clarify policy statements and member communications to ensure that **Kaiser** sends the member a written notice of the denial for an expedited resolution *within two calendar days of receipt* of the appeal.

The appeals policy specified that timely filing requirements for continuation of benefits were within 10 calendar days *after the health plan mails the appeal decision*. The timely filing requirements when the member requests continuation of benefits are within 10 days of the original notice of action (not the appeal decision) or the intended effective date of the proposed action, whichever is later. **Kaiser** must specify that timely filing requirements for requesting continuation of benefits during an appeal or State fair hearing are defined as on or before the later of the following: within 10 days of the Contractor mailing the notice of action or the intended effective date of the proposed action.

The provider manual did not inform providers of the details of the grievance and appeal processes including time frames for filing grievances and appeals, State fair hearing information, continuation of benefits during an appeal or State fair hearing, or that a provider may file a grievance or appeal on behalf of the member. In addition, the provider manual defined the time frame for responding to a grievance as 30 calendar days, either orally or in writing, which is inaccurate for CHP+ members. **Kaiser** must develop mechanisms to ensure that all providers are informed, at the time of contracting, of the detailed grievance and appeals information outlined in 10 CCR 2505-10, Section 8.209.3.B.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

The policies, procedures, and processes submitted by **Kaiser** to address the requirements for Provider Participation and Program Integrity represented a combination of policies and processes from the Kaiser Foundation Health Plan of Colorado (KFHP CO); Colorado Permanente Medical Group (CPMG); and the national entity, referred to collectively as Kaiser Permanente (KP). Functional ownership for these policies, procedures, and processes were appropriately aligned with the respective responsibilities and roles at the local, regional, and national health plan level.

All providers, whether employed or contracted with **Kaiser,** are subject to credentialing and recredentialing policies and procedures in accordance with the National Committee for Quality Assurance (NCQA) standards. **Kaiser** submitted a credentials program report which demonstrated that credentialing standards, annual goals, and objectives were being met. Some sub-specialty provider credentialing was delegated to University Physicians, Inc. (UPI). These specialists served as contracted providers for the **Kaiser** CHP+ population. Providers employed and contracted with **Kaiser** received relevant training and were monitored for quality, appropriateness, outcomes, and compliance with medical record documentation standards. **Kaiser** staff members stated that **Kaiser** does not object to provision of services based on moral/religious grounds and that any member receiving services from a provider with moral objections to provision of needed services would be directed to an alternate care provider. During the on-site review, **Kaiser** staff demonstrated a robust monitoring system used for monthly screening of providers, employees, directors, and contractors for exclusion from federal and state programs, as defined in the requirements. **Kaiser** evaluated network adequacy quarterly and indicated that there were no network deficiencies. Additionally, **Kaiser** demonstrated that it had a process in place for managing provider requests to join its network and stated that provider applications are generally only considered when specific network deficiencies arise. **Kaiser** has instituted step-by-step instructions for reporting any adverse licensure or professional review actions to the National Practitioner Data Bank and other regulatory bodies as required. **Kaiser** had comprehensive advance directive (AD) policies and procedures and provided its members with an AD guide via the member portal of the KP website. In the event the AD laws had changed, **Kaiser** had the appropriate support mechanisms to operationalize the changes in laws and notify its members within the required time frames. **Kaiser** had a comprehensive compliance plan in place with appropriate training, monitoring, and confidential reporting mechanisms in place to guard against fraud, waste, and abuse.

Summary of Findings Resulting in Opportunities for Improvement

Overall, the **Kaiser** CHP+ processes related to Provider Participation and Program Integrity were comprehensive and actively implemented. HSAG recommends that once **Kaiser** develops a policy that it will not discriminate against providers (see required actions), it communicates the policy to providers prior to credentialing or recredentialing.

Summary of Required Actions

Kaiser's Principles of Responsibility manual, which serves as **Kaiser**'s code of conduct, discussed **Kaiser**'s commitment to nondiscriminatory practices, but did not specifically state that it will not discriminate against its providers, as defined in the requirement. In addition, **Kaiser** did not provide a policy which addressed, nor did the New Provider Agreement Template address, non-discrimination against providers. **Kaiser** must develop a policy statement that it does not discriminate against any provider solely on the basis of the provider's license or certification and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as stated in 42CFR438.12(a)(1) and (2) and 42CFR431.214(c).

As identified in 42CFR438.106 (Requirement #13 of this standard), providers may not bill CHP+ members for "covered services provided to the member for which the Contractor does not pay the health care provider." **Kaiser**'s Provider Services Agreement included this requirement, yet on-site record reviews identified that a subcontracted provider had aggressively pursued a member for charges denied to the provider by **Kaiser**. **Kaiser** must develop effective processes, controls, and communications to ensure that providers will not hold **Kaiser** members liable for covered services as required in 42CFR428.106. When made aware of such situations, **Kaiser** staff must expeditiously follow up on provider compliance issues related to the Provider Agreement to ensure that members are not adversely affected by **Kaiser**'s payment decisions based on provider's procedural noncompliance.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

Kaiser had agreements in place with UPI for sub-specialty physician credentialing, the Children's Hospital Association for the after-hours call center, and Employers Mutual, Inc., for third-party administration services for transportation claims. **Kaiser** provided evidence of monitoring its delegates and working with the delegates to correct deficiencies found via monitoring activities.

Summary of Findings Resulting in Opportunities for Improvement

The Delegation Oversight Program Committee evaluated the quality of care and service provided to **Kaiser** Colorado region members through continuous oversight of each delegated entity's program, performance reports, and corrective action plans. The Delegation Oversight Program Committee Charter indicated that the committee meets quarterly; however, during the site visit **Kaiser** staff members were unable to provide evidence of the committee meetings held or discuss outcomes from their committee meetings in 2014. Some subcontractor reports indicated performance issues with delegates, yet the committee may not subsequently meet for timely review of corrective action reporting. Therefore, HSAG recommends that the Delegation Oversight Program Committee be engaged more frequently to review performance metrics and to ensure that delegated subcontractors consistently meet contracted performance standards.

Summary of Required Actions

No actions were required for this standard.