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

FY 2014–2015 Site Review Report

for

Kaiser Permanente Colorado

April 2016

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

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ACKNOWLEDGMENTS AND COPYRIGHTS

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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 FY 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015. 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 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 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 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 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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)
III Coordination and Continuity of Care	12	12	9	2	1	0	75%
IV Member Rights and Protections	5	5	3	1	1	0	60%
VIII Credentialing and Recredentialing	48	47	47	0	0	1	100%
X Quality Assessment and Performance Improvement	15	15	10	5	0	0	67%
Totals	**80**	**79**	**69**	**8**	**2**	**1**	**87%**

Table 1-2 presents the scores for **Kaiser** for the credentialing and recredentialing 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)
Credentialing	90	87	87	0	3	100%
Recredentialing	90	84	84	0	6	100%
Totals	**180**	**171**	**171**	**0**	**9**	**100%**

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

Kaiser submitted policies and procedures related to member care coordination in the Primary Care Medical Home (PCMH) as well as care coordination by the Pediatric Care Coordination (PCC) team, which demonstrated processes for coordinating medical and non-medical services for CHP+ members. Primary care providers or hospitals referred pediatric members with complex medical, behavioral, and/or social needs to the PCC team. **Kaiser** also had designated care coordination teams for members with special healthcare needs, including asthma care, developmental disability and autism care, perinatal newborn, community resource, and nutrition teams. Members could be referred to or were auto-enrolled (based on designated diagnoses) in these programs. The care coordination teams and PCMH providers communicated care coordination activities through the HealthConnect electronic medical record (EMR) system. Staff stated that Children's Hospital Colorado, a contracted network provider that provided many specialist services and programs for **Kaiser** pediatric members with special healthcare needs, could also access and enter information into the HealthConnect EMR. The PCC team and the community resources team were the primary sources for coordinating with external agencies and community-based organizations such as the county departments of human services (DHSs), Hunger Free Colorado, financial support resources, and schools. The PCC intake assessment, embedded in the EMR, demonstrated comprehensive assessment and documentation of medical and behavioral health needs, developmental needs, functional status, external resource needs (financial, food, home health), transportation and school information, safety risks, and language/cultural needs. A PCC case presentation demonstrated coordination with multiple internal and external services for a specific member with complex care needs.

Kaiser had multiple mechanisms to align newly enrolled members with primary care providers. **Kaiser** administered a brief health questionnaire to all members who contacted the system after enrollment, followed by more detailed assessment, as indicated, to screen members for special healthcare needs. Member assessments were entered into HealthConnect, which enabled sharing among all plan and major contracted providers. **Kaiser** also shared assessments with external providers and organizations through secure mailings and/or fax communications. Staff members stated that **Kaiser** providers engaged members/parents in assessment and treatment planning and requested a release of information to allow **Kaiser** to share member information with appropriate entities. **Kaiser** allowed members to self-refer to specialists within the **Kaiser** system, and **Kaiser** providers assisted members with referrals to sub-specialists outside the plan to expedite the referral process. Staff stated that necessary access to out-of-network providers was generally authorized for a period of six months by Utilization Management.

Summary of Findings Resulting in Opportunities for Improvement

Care coordination policies described care coordination processes at a very high level and often did not include specific procedures and accountabilities for care coordination components described in the policies. Although the HealthConnect system facilitated communication of care coordination assessments and activities among multiple providers and teams, entering information into a member record does not ensure that other providers and teams access or use the information. HSAG cautioned that internal coordination among multiple specialty-focused teams—coordinating the coordinators—may present a challenge. HSAG recommends that **Kaiser** enhance its policies to include more definitive procedures and accountabilities and consider processes such as conducting multi-team training and/or establishing a lead coordinator to ensure that members with multidimensional needs receive cohesive and comprehensive care coordination.

While the brief health questionnaire administered to new members after enrollment had a relatively high response rate, the questionnaire did not directly ask if the member was receiving ongoing services from another provider or whether the member had special healthcare needs. HSAG observed that this may be a missed opportunity for **Kaiser** to identify new members with special healthcare needs or who are involved in an ongoing course of treatment. In addition, **Kaiser** only administered the enrollment assessment after the newly enrolled member contacted **Kaiser**. **Kaiser** is required to assess members with special healthcare needs within 30 days of enrollment; therefore, HSAG recommends that **Kaiser** consider enhancing the new member welcome letter to more directly encourage members with special healthcare needs to call member services as soon as possible.

Kaiser was unable to demonstrate that member treatment plans include the required elements of treatment objectives, treatment follow-up, and monitoring of outcomes. Provider communications such as the provider manual also did not identify the required components of a CHP+ member treatment plan. HSAG recommends that **Kaiser** consider enhancing provider materials or trainings to communicate the required elements of a CHP+ member treatment plan.

Summary of Required Actions

Kaiser demonstrated that pediatric members receive a thorough assessment of needs, documented in the HealthConnect EMR. HealthConnect also documented interventions in response to the assessment. However, **Kaiser** was unable to demonstrate that the treatment plan included the required elements. **Kaiser** must provide evidence that the member treatment plan includes treatment objectives, treatment follow-up, monitoring of outcomes, and revision as necessary.

The pediatric care coordination intake assessment as well as embedded HealthConnect protocols applicable to select populations of members included statements documenting that the member/parent participated in the assessment and agreed to the care coordination plan. However, records of CHP members not engaged in special programs contained no similar documentation. **Kaiser** staff members stated that **Kaiser** was aware of this omission, was dissatisfied with current mechanisms for documenting member/family involvement in treatment planning, and was engaged in a joint pilot project with Children's Hospital Colorado providers to develop and test more robust

mechanisms for documenting CHP+ and Medicaid member/family involvement in and consent to treatment planning. **Kaiser** must develop procedures to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.

Kaiser did not have written procedures that addressed continuity of care for newly enrolled members involved in an ongoing course of treatment. The CHP+ Evidence of Coverage (EOC) stated that **Kaiser** would provide continuity of care (defined as "transitional care and treatment received from non-plan providers") for members if they meet certain eligibility criteria. The EOC did not clearly state that new members involved in an ongoing course of treatment may continue services for the time frames and circumstances specified in the requirement. Staff members further stated that the utilization management team would determine whether the member's needs could be met within the **Kaiser** provider network before approving continuing care from a non-plan provider. This process is in conflict with CHP+ requirements. **Kaiser** must demonstrate that procedures allow for continuity of care for newly enrolled members, as outlined in the requirement. **Kaiser** must also clearly inform newly enrolled members involved in an ongoing course of treatment that they may continue care for 60 days with the current provider, receive continued ancillary services for 75 days, and continue (in the second or third trimester of pregnancy) with the current provider until completion of postpartum care.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

Kaiser had documents and processes to ensure provision of member rights and to communicate expectations to members, providers, and staff. **Kaiser** had a clear passion for ensuring that members are the primary focus and at the center of **Kaiser**'s mission. The *Principles of Responsibility* document articulated **Kaiser**'s expectation of creating positive relationships with members, employees, and providers; and it was evident that interviewed staff members were committed to this vision.

Summary of Findings Resulting in Opportunities for Improvement

Kaiser notified its members of their rights in the *Evidence of Coverage* booklet and the *Member Resource Guide*. Providers were notified of member rights in the provider and affiliated provider manuals. **Kaiser** staff members were notified of member rights in new hire and annual training. **Kaiser** also included member rights on their website, kp.org. **Kaiser**'s various member rights documents contained inconsistent language, some of which was more member-friendly. HSAG recommends that **Kaiser** consider the use of consistent member-centric language in all documents that reflect member rights information. HSAG also recommends that **Kaiser** includes procedures in an overall member rights policy referencing topic-specific materials to ensure that all documents are updated consistently.

Summary of Required Actions

Although **Kaiser** had numerous documents that addressed member rights, **Kaiser** had no policy and procedure regarding CHP+ member rights. **Kaiser** must develop an overview member rights policy which describes all member rights afforded to CHP+ members.

Kaiser's multiple documents used to communicate member rights included inconsistent and incomplete listings of member rights.

- The EOC did not address the right to receive information in a manner appropriate to the member's condition and ability to understand; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; the right to request amendment of medical records; or the right to be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.
- The member resource guide, provider manual, and affiliated provider manual did not address the right to obtain family planning services from any duly licensed provider in or out of network without a referral.
- The kp.org website listing of member rights was different from the rights outlined in **Kaiser**'s other documents.

Kaiser must revise its documents to include all member rights outlined in the requirement and as noted. **Kaiser** must ensure that any other documents, including listings on kp.org, that reference or describe member rights, are revised to be inclusive of all rights described by 42CFR438.100(b)(2) and (3) and CHP+ contract Exhibit A4.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

Kaiser's policies and processes across the credentialing program were thorough and robust and demonstrated clear compliance with National Committee for Quality Assurance (NCQA) policies and processes. The credentialing and recredentialing files for individual practitioners and organizational providers were well-organized and complete. The credentialing and recredentialing files reviewed on-site demonstrated that staff members implemented **Kaiser**'s policies and procedures as written.

Kaiser provided comprehensive procedures and evidence to demonstrate compliance with nondiscrimination, reconciliation with provider listings, ongoing monitoring of sanctions, complaints, adverse events, and appeal requirements.

Kaiser demonstrated evidence of oversight of all delegated credentialing and recredentialing activities, including receipt of contractually-required reports and completion of annual audits. **Kaiser**'s delegation to University Physicians, Inc. included the use of a NCQA-certified verification organization (CVO), further confirming **Kaiser**'s commitment to NCQA standards. Record reviews

confirmed that credentialing and recredentialing were completed within required time frames for practitioners and organizational providers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to credentialing and recredentialing.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

Kaiser had an *Integrated Patient Care Quality Program* description that applied to all members of the **Kaiser** system. The program description outlined a comprehensive program with multi-layered analyses, accountabilities, and oversight functions. The Service Quality and Resource Management Committee (SQRMC) is the ultimate oversight body for the Quality Assessment and Performance Improvement (QAPI) program. The SQRMC meets monthly to review and approve reports from multiple subcommittees aligned with the functional departments of the organization. **Kaiser** conducted ongoing review of quality monitoring measures and implementation of quality initiatives through numerous committees, task forces, and teams. The annual *Quality, Service & Resource Stewardship Program Evaluation* report to the SQRMC, applicable to the entire population of the **Kaiser** system, included performance goals, measurement outcomes, barriers, and continued opportunities for improvement for numerous quality activities, including HEDIS measures, member satisfaction data, utilization trends, and special projects. The report was heavily weighted toward the Medicare and commercial member populations. Staff members stated that the Medicaid and Charitable Program (MCP) management staff performed "intermediary" oversight of quality data and initiatives related specifically to the CHP+ line of business, such as CHP+ performance improvement projects (PIPs), HEDIS measures, CAHPS results, grievances and appeals, quality of care (QOC) concern data, and care coordination activities. The Triple Aim Governance (TAG) committee performed review and oversight of quality indicators and initiatives related to the entire pediatric population.

Kaiser had robust health information systems that calculated information obtained through the claims system and the HealthConnect EMR and generated and distributed reports to the various functional teams for review and analysis. **Kaiser** demonstrated numerous reports for monitoring clinical performance indicators, utilization measures, and targeted quality initiatives of the specialty program teams. In addition, the system produced online, provider-specific dashboard reports for provider oversight of member satisfaction, access, utilization, and select HEDIS measures. **Kaiser** had clinical practice guideline policies and procedures which described the role of the Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC) and defined robust processes for the development, approval, and implementation of clinical practice guidelines. **Kaiser**

demonstrated having adopted clinical guidelines for well-child care, prenatal services, and several special needs conditions applicable to CHP+ members. **Kaiser** distributed practice guidelines through the online clinical library and, as appropriate, integrated them into the documentation requirements in the HealthConnect EMR. Guidelines were translated into member-friendly materials through *Healthwise* publications and also were available to members on the **Kaiser** website. QOC concerns were identified through member grievances, staff members, or providers and thoroughly investigated by the risk management department and, as appropriate, the peer review process of the Colorado Permanente Medical Group (CPMG).

Summary of Findings Resulting in Opportunities for Improvement

Kaiser estimated that its 7,000 CHP+ members make up slightly over 1 percent of its entire 630,000 membership. **Kaiser**'s Integrated Patient Care Quality Program was applicable to the entire **Kaiser** population, and the annual SQRMC program evaluation report as well as ongoing monitoring of many performance indicators were primarily related to the commercial and Medicare populations. Although HSAG acknowledges that quality interventions and service initiatives applicable to the entire **Kaiser** membership may also include CHP+ members, HSAG cautioned that **Kaiser**'s understanding of the quality of service being delivered to CHP+ members could be limited by the systemwide orientation of the QAPI program. Therefore, HSAG recommends that **Kaiser** define mechanisms to more explicitly document analyses and initiatives related to the CHP+ and/or pediatric populations. HSAG noted that **Kaiser** has resources in place—MCP management team and TAG group—for analyzing CHP+-specific quality indicators as well as results for the overall pediatric population. However, documentation of these activities was limited; and results were not formally reported through the quality oversight structure. HSAG recommends that these teams document all findings, analyses, and recommendations related to CHP+ and/or pediatric service line quality improvement activities and formally report results to the appropriate quality oversight bodies, including the SCRMC, periodically (at least annually).

Summary of Required Actions

Kaiser provided screen shots showing elements of a postpartum visit documented in the HealthConnect EMR, which *may* indicate **Kaiser** has developed clinical treatment guidelines for postpartum care; however, **Kaiser** did not provide documentation of actual postpartum clinical practice guidelines. **Kaiser** must adopt or provide evidence that the CKCN/GLC has adopted postpartum clinical treatment/practice guidelines.

Clinical practice guideline policies and procedures stated, and staff members confirmed, that clinical guidelines are formally reviewed and updated by committee every two years. **Kaiser** must ensure that clinical practice guidelines applicable to CHP+ members are reviewed and updated annually.

Kaiser demonstrated ongoing calculations and analysis of numerous HEDIS measures for its entire population, with trending and review by various committees and program staff periodically, before being reported to the SQRMC. While some HEDIS measures specifically addressed the pediatric population, few measures were trended and analyzed specific to the CHP+ line of business. Staff

stated that the CHP+ management team reviewed and analyzed CHP+ HEDIS measures, but the team maintained no documentation of its reviews. **Kaiser** must document that it analyzes, responds to, and reports to quality oversight committees the results of HEDIS measures specific to the CHP+ line of business.

The *CHP MCO – Quarterly Report* included data and analysis of member disenrollments, grievances and appeals, QOC concerns, and provider network adequacy. However, **Kaiser** could not provide documentation that it reviewed CAHPS or other member satisfaction measures specific to the CHP+ population. (**Kaiser** documented results of member satisfaction surveys, the CAHPS survey, and grievance and appeal data related to commercial and Medicare members.) During on-site interviews, staff members stated that CHP+ management team reviewed and analyzed the CHP+ CAHPS results, but the team did not document its analysis. **Kaiser** must document that it analyzes, responds to, and reports to quality oversight committees the results of the CHP+ CAHPS.

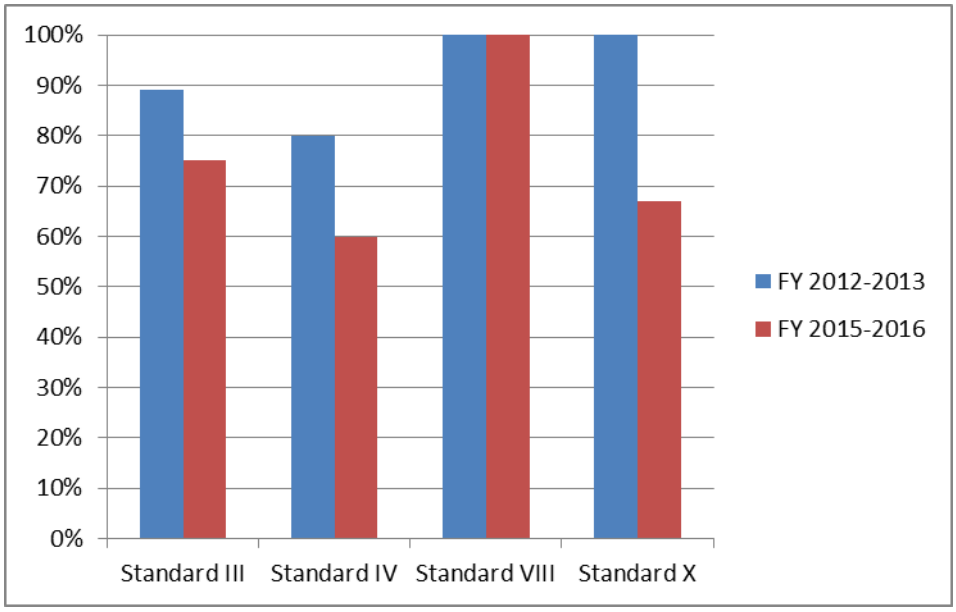
The annual SQRMC program evaluation, applicable to the entire **Kaiser** population, included limited results specific to either the CHP+ or pediatric populations. **Kaiser** also did not produce an annual CHP+ quality report per the CHP+ contract requirements. **Kaiser** must implement a process for evaluating the effectiveness of the QAPI program for CHP+ members. **Kaiser** must produce an annual CHP+ QAPI report that addresses all requirements defined in section 4.7.2.1 of its CHP+ contract with the Department.

Comparison of Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **Kaiser**'s contract with the State may have changed and may have contributed to performance changes.

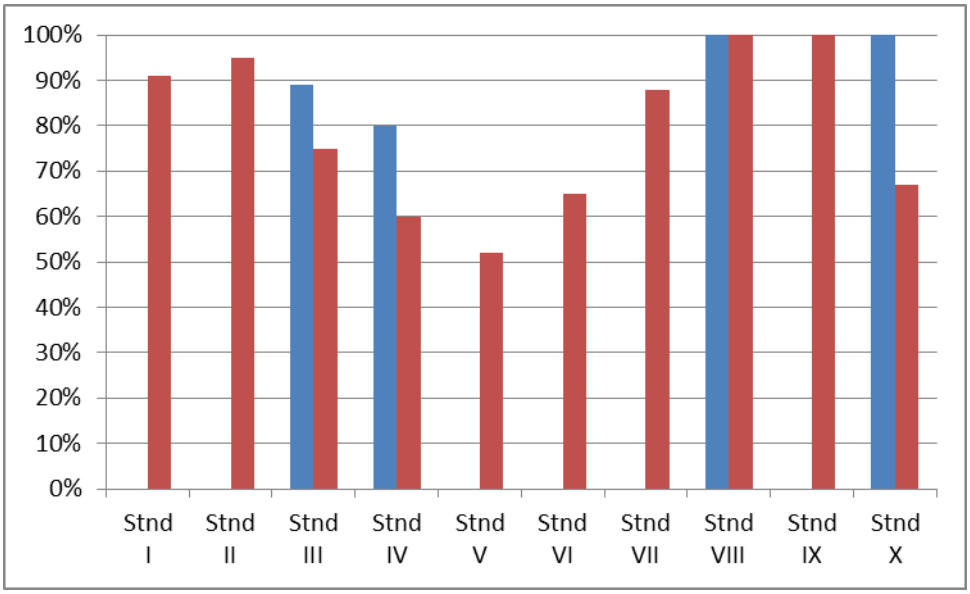
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past four years of compliance monitoring. The figure compares the score for each standard across two review periods, as applicable, and may be an indicator of overall improvement.

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



Note: Results shown in blue are from FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

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

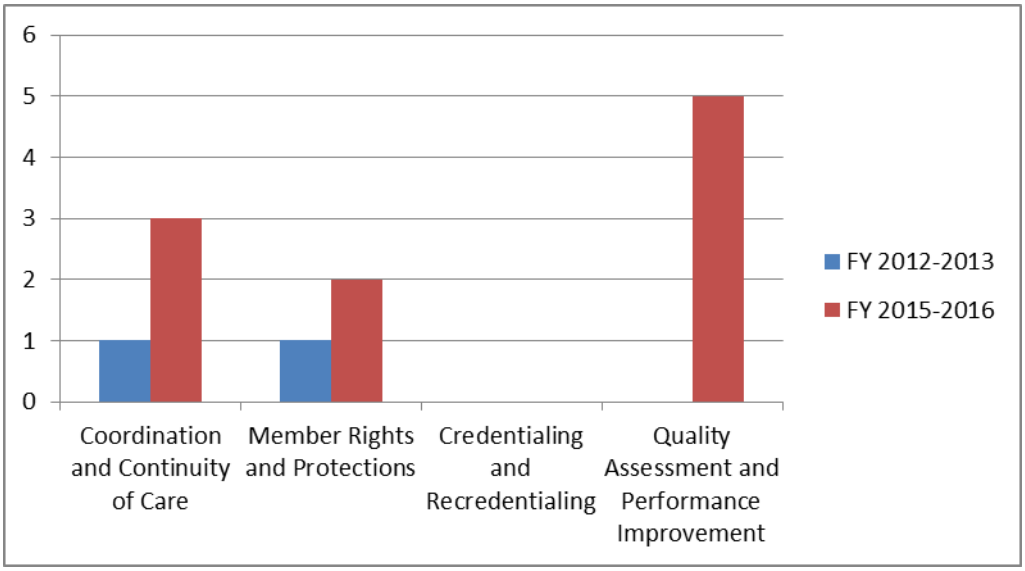
Table 2-1—List of Standards by Review Year

Standard	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services		X		
II—Access and Availability		X		
III—Coordination and Continuity of Care	X			X
IV—Member Rights and Protections	X			X
V—Member Information			X	
VI—Grievance System			X	
VII—Provider Participation and Program Integrity			X	
VIII—Credentialing and Recredentialing	X			X
IX—Subcontracts and Delegation			X	
X—Quality Assessment and Performance Improvement	X			X

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **Kaiser**'s contract with the State may have changed and may have contributed to performance changes.

Figure 2-3—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard

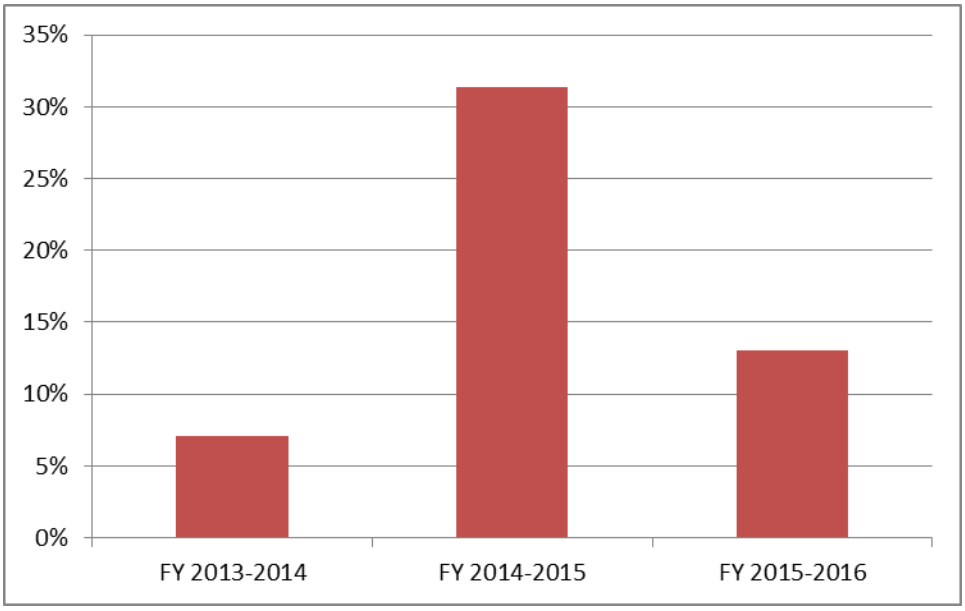


Note: **Kaiser** had no required actions for Credentialing and Recredentialing or Quality Assessment and Performance Improvement resulting from the FY 2012–2013 site review. **Kaiser** also had no required actions for Credentialing and Recredentialing resulting from the FY 2015–2016 site review.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four 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+ credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the health plan's administrative records related to CHP+ credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and 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 four standards chosen for

the FY 2015–2016 site reviews represent a portion of the CHP+ managed care requirements. These standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal healthcare 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 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the FY 2014–2015 site review, **Kaiser** was required to address seven *Partially Met* elements and four *Not Met* elements in Standard V—Member Information, seven *Partially Met* elements and two *Not Met* elements in Standard VI—Grievance System, and one *Partially Met* element and one *Not Met* element in Standard VII—Provider Participation and Program Integrity.

Summary of Corrective Action/Document Review

Kaiser submitted its proposed CAP in May 2015. After reviewing **Kaiser**'s proposed plan, HSAG and the Department approved some of the proposed actions and required additional detail for others. **Kaiser** began submitting documents to demonstrate completion of the plan in August 2015. As of November 2015, **Kaiser** had completed 11 of the 22 required actions. **Kaiser** proposed, and the Department approved, a substantial rewrite of **Kaiser**'s Evidence of Coverage (EOC) to comply with the requirement for ease of understanding for members—with other interim documents produced to correct critical elements of inaccuracy in information for members. The critical corrections to the EOC were completed in August 2015. The rewrite of the EOC must be completed on or before July 31, 2016. **Kaiser** completed eight of the nine corrective actions for Standard VI—Grievance System and one of two corrective actions for Standard VII—Provider Participation and Program Integrity.

Summary of Continued Required Actions

At the time of the FY 2015–2016 site review, 11 of the FY 2014–2015 required actions for **Kaiser** were continuing. Eight of the continued corrective actions related to Standard V—Member Information were to be addressed in the rewrite of the member EOC. **Kaiser** also needed to complete one additional requirement in Standard V related to procedures and training, one outstanding item in Standard VI—Grievance System that required revisions to the provider manual, and one item in Standard VII—Provider Participation and Program Integrity that required policy revisions. HSAG and the Department will continue to work with **Kaiser** to ensure completion of all FY 2014–2015 required actions.

Appendix A. Compliance Monitoring Tool for Kaiser Permanente Colorado

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living. *42CFR438.208(b)(2)* Contract: Exhibit A4—2.7.4.1	Several policies are included which describe the ways that KP ensures continuity of care, access to care, and attention to members' individual and special needs. Documents: 1. 3.1.1 Care Coordination Pediatric Signed 2013 pg 1-2 2. Integration of Care in KPCOs Patient Centered Medical Home (PCMH)- pg 1-2 3. QI 503 Accessibility of Services Report 2015 pg 1-5 4. Transition of Care P&P- pg 8, 15-16 6. Written and Verbal Translation Interpretation Services Policy and Procedure pg 1-10 7. Cur-Policy 7204-07 Accessibility of Services (QI500)- pg 1-11 17. job_aid_bh_care_plan 26. Special Communications Needs P&P- PG 1-11	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources. Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by	The attached policies and work-flows demonstrate the ways in which KP coordinates care for children with special needs, follows up post hospitalization, and transitions care if necessary. It also includes ways in which members are referred to community resources when appropriate. Documents: 1. 3.1.1 Care Coordination Pediatric Signed 2013 pg 1-2 2. Integration of Care in KPCOs Patient Centered Medical Home (PCMH)- pg1-2 3. QI 503 Accessibility of Services Report 2015 pg 1-5 4. Transition of Care P&P- pg 8, 15-16 8. PCMH Comprehensive Health Assessment Documentation pg 1-8 9. Peds Special Needs example of V code in Problem List pg 1 10. Early Interventions CO Referral Form pg 1-2 11. PCC Hosp Discharge Workflow- pg 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
specialists, subspecialists, and community-based organizations. Contract: Exhibit A4—2.7.4.3.2; 2.7.4.3.3; 2.7.4.3.5; 2.7.5.5	12. Revised PCC flyer 2015- pg 1 13. ExternalPatientLowIncomeFlyer_Eng_Spanish_March2015- pg 1-2 14. Community Specialist and Social worker flyer pg 1 15. Community Specialists and Social Worker Locations- pg 1 7. Cur-Policy 7204-07 Accessibility of Services (QI500)- pg 1-11 16. Medicaid_discharge_wkflw_2015- pg 1 17. Job aid BH care plan pg 1-2 19. Cco_healthy_living_resource_guide pg 1-10 59. Clinical Library-Acute Bacterial Rhinosinusitis- pg 1 141. QI 1116 Exchange of Information- Activity-Cont and Coord of Care-Exchange of Info pg 1-5, 9	
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. ◆ Upon enrollment, the Contractor makes at least one attempt to contact the member with information on options for selecting a PCP. ◆ If the member does not select a PCP within 10 days, the Contractor assigns the member to a PCP and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. ◆ The Contractor notifies the PCP of newly assigned members in a timely manner. ◆ The Contractor grants a member's request to change his/her PCP, as reasonable and practical. *42CFR438.208(b)(1)* Contract: Exhibit A4—2.5.8.2	These documents include the welcome information provided when a member's ID card is generated, which indicates how to connect with a PCP. The PCPs are informed that new members have been added to their panel based on regular panel reports. *The EOC is currently under revisions for readability to ensure that it is written at a 6th grade reading level. Documents: 20. 2015_01_08_IDCardBilingualInsert_DenverBoulder_FINAL- pg 1-2 22. 2015_01_08_IDCardBilingualInsert_DenverBoulder_FINAL- pg 1-2 23. WelcomePPSSPeds0_13Letter pg 1 21. WelcomeSelfSelPeds0_13Letter pg 1 *53. CHP+ EOC- pg 4 under "Your or your Child's(ren's) Primary Care Plan Physician"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate healthcare professionals. ◆ The Contractor will assess members with special healthcare needs within 30 days in order to identify ongoing conditions that require a course of treatment or regular care monitoring. *42CFR438.208(c)(2)* Contract: Exhibit A4—2.7.4.3.1.1; 2.7.5.3	KP utilizes a Brief Health Questionnaire to onboard new members and uses the responses to generate appropriate follow-up with a health care professional. This process is outlined in the "New member BHQ Process" document, and several clinical guidelines are provided to demonstrate the follow-up that takes place depending on need. Documents: 2.Integration of Care in KPCOs Patient Centered Medical Home (PCMH)- pg 1-2 8. PCMH 2C1-9- Comprehensive Health Assessment Document, pg 1-8 27. PEDIATRIC AND ADOLESCENT PREVENTIVE MEDICINE RECOMMENDATIONS_October 2015- pg 1-3 28. well_child_care_health_connect_resources pg 1-3 30. Referral Pathways for Developmental Delay and Autism- pg 1-4 31. Clinical Library- Health Maintenance Pediatric- pg 1 32. Clinical Library- Development and Behavior- pg 1 9. Peds Special Needs example of V code in Problem List pg 1 34. Pediatric Intake pg 1-2 (available on-site) 35. New Member BHQ Process- pg 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor shares with other healthcare organizations serving the member with special healthcare needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A4—2.7.5.2	The Care Everywhere job aid below describes how network partners of KP may access a member's health record and input information related to the members' care. Documents: 9. Peds Special Needs example of V code in Problem List pg 1 30. Referral Pathways for Developmental Delay and Autism- pg 1-4 37. JA_Care Everywhere_Request_Records_8132015 pg 1-2 11. PCC Hosp discharge workflow pg 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A4—2.7.4.3.1.2; 2.7.4.3.1.3	Individual treatment plans are developed following a list of standardized questions called "Smart Sets" which are built-into the Health Connect and are company-confidential. The specific Pediatric Intake smart-set will be available to review onsite. Documents: 2. Integration of Care in KPCOs Patient Centered Medical Home (PCMH)- pg 1-2 8. PCMH Comprehensive Health Assessment Documentation pg 1-8 9. Peds Special Needs example of V code in Problem List pg 1 30. Referral Pathways for Developmental Delay and Autism- pg 1-4 34. Pediatric Intake pg 1-2 (available on-site)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Kaiser Permanente (Kaiser) demonstrated that pediatric members receive a thorough needs assessment that is documented in the HealthConnect electronic medical record (EMR). Although the EMR also documented an associated set of interventions in response to the assessment, Kaiser was unable to demonstrate that the treatment plan included the required elements—treatment objectives/goals, planned follow-up, or monitoring of outcomes of the treatment plan. In addition, provider communications (e.g., provider manual) did not address the requirement for a treatment plan that included the specified elements.		
Required Actions: Kaiser must provide evidence that the member treatment plan includes treatment objectives, treatment follow-up, monitoring of outcomes, and revision as necessary.		
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special healthcare needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A4—2.7.4.3.1.4	The policies below describe how KP communicates and accommodates members with special health care needs. Members may also self-refer to specialists as outlined in the EOC. Documents: 8. PCMH Comprehensive Health Assessment Documentation pg 1-8 9. Peds Special Needs example of V code in Problem List pg 1 30. Referral Pathways for Developmental Delay and Autism- pg 1-4 34. Pediatric Intake pg 1-2 (available on-site) 53. CHP+ EOC- pg 4 26. Special Communications Needs P&P- PG 1-11	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A4—2.7.4.1, 3.1.4.3	These documents describe KP's privacy policies for members. For the purposes of these policies, Child Health Plan Plus is considered a group health plan. Documents: 48. FINAL_KP_InfoSec_Policy-June72012—Colorado- pgs 11, 32, 65 50. Policy CO.RCO.PRIV.14 Minimum Necessary 51. Policy CO.RCO.PRIV.7 Group Health Plans-KP Disclosures of Enrollee PHI 52. Policy CO.RCO.PRIV.8 HIPAA Authorization	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A4—2.7.4.3.4	By its nature as a program for children, parental involvement is key to all care planning for the CHP+ program. The Pediatric-Intake smart-set, which will be available on-site, demonstrates questions that are asked of the parents during an intake visit. Documents: 53. CHP+ EOC- pg 37 and 40 52. Policy CO.RCO.PRIV.8 HIPAA Authorization 34. Pediatric Intake pg 1-2 (available on-site)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The pediatric care coordination intake assessment and some HealthConnect protocols (smart sets) applicable to select populations of members (e.g., members transitioning care settings) included statements certifying that the member/parent participated in the assessment and agreed to the care coordination plan. However, records of the general population of CHP+ members (i.e., those not engaged in special programs) contained no similar documentation. Kaiser had no provider protocols or instructions to require that members/family members be involved in treatment planning and consent. During on-site discussions, staff members stated that Kaiser was collaborating with Children's Hospital Colorado providers to develop and test more robust mechanisms for engaging and documenting CHP+ and Medicaid members and families in treatment planning and consent and had initiated pilot testing of enhanced methodologies at one

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
clinic site. Staff members stated that Kaiser intends to implement improved mechanisms to document member and family involvement in care planning as a result of the project.		
Required Actions: Kaiser must implement procedures to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.		
10. The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care. Contract: Exhibit A4—2.7.4.3.6; 2.7.5.1.1; 2.7.5.1.2; 2.7.5.1.3	The CHP+ EOC describes member rights related to continuity of care. Documents: 53. CHP+ EOC- pg 6-7	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Kaiser had no policies and procedures that addressed this requirement; however, the CHP+ EOC stated that Kaiser will provide continuity of care (defined as "transitional care and treatment received from non-plan providers") for members who meet certain eligibility criteria and who submit a complete application for continuity of care services. The listed eligibility criteria were unclear as to whether continuity of care applies to newly enrolled members involved in an ongoing course of treatment. The EOC also stated the transition period for continuity of care "will not exceed a period of sixty (60) days" (the CHP+ requirement is explicitly 60 days). The EOC did not inform members that *new* members involved in an ongoing course of treatment may continue services for the required time fames outlined in the requirement. During on-site interviews, staff members further stated that the Kaiser utilization management team would determine whether the member's needs could be met within the Kaiser provider network before approving transitional or continuing care from a non-plan provider, which is in conflict with CHP+ requirements.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Required Actions: Kaiser must provide for and clearly inform newly enrolled members with special healthcare needs involved in ongoing courses of treatment that they may continue care for 60 days with the current provider, receive continued ancillary services for 75 days, and continue (in the second or third trimester of pregnancy) with the current provider until completion of postpartum care. Kaiser must also demonstrate that procedures allow for continuity of care for newly enrolled members, as outlined in the requirement.		
11. If necessary primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. Contract: Exhibit A4—2.7.5.2	Out-of-Network referrals are available for medically-necessary services not provided by KP. If out-of-network services result in a denial, these are reviewed according to the Out of Plan Referral Review policy. Documents: 53. CHP+ EOC- pg 4 83. Resource Stewardship Out of Plan Referral Review- pg 1-3 5. Authorization of Services pg 1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor allows members with special healthcare needs direct access to a specialist (for example, through a standing referral), as appropriate for the member's condition, and/or to maintain these types of specialists as PCPs. *42CFR438.208(c)(4)* Contract: Exhibit A4—2.7.5.4	Self-referral to specialists is available to members, and the time frame of the authorization is provided under the Authorization of Services policy, and varies based on the requested service, but are usually for 6 months. Documents: 53. CHP+ EOC- pg 4 5. Authorization of Services pg 1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	2	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	9

Total Score ÷ Total Applicable	=	75%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A4—3.1.1.1	Each member's rights are outlined in the EOC that the member receives each year as well as in the Provider Manual and on KP.org. There is a section referring to the way in which we treat our members that exists in the Principles of Responsibility which each Kaiser Permanente employee receives upon their employment with Kaiser Permanente. Documents: 53. CHP+ EOC- pg 40 55. Principles of Responsibility_Kaiser Permanente Code of conduct- pg7 and 12 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 182-188 56. Kp.org Member Rights Onsite documents reviewed by HSAG: Member Resource Guide 6592-008 Development and Distribution of Required Information w Signatures 24Mar14 & Attachment A	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Findings:
Although Kaiser had several documents that listed member rights, Kaiser had no member rights policy. (HSAG had provided a recommendation for Kaiser to develop a member rights policy in previous site review of this standard.)
During on-site interviews, staff members verbalized an understanding of the *Principles of Responsibility (POR)*, which is the governing document for staff. While the *POR* included no description of member rights, it clearly described the culture of dignity and respect expected of all staff, especially when interacting with members. All staff interviewed demonstrated a passion for the *POR*. Members received member rights information in the Evidence of Coverage (EOC) and were also encouraged to access the Kaiser website for information. During the on-site interview, staff members stated that the *Member Resource Guide*, which included member rights, was provided to all members during 2015. Providers received member rights information in the provider manual, distributed upon hire/contracting, and were encouraged to access the Kaiser website for information; providers also received an annual email related to member rights. Staff members were trained on the *POR* (including member rights) upon hire as well as annually and were also encouraged to access the Kaiser website.

Documents outlining member rights were inconsistent, and the affiliated provider manual included much more descriptive language than the member EOC. HSAG advised Kaiser that an overall member rights policy might include procedures referencing topic-specific materials to ensure that all documents are updated consistently if/when a change in member rights language occurs.

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Required Actions: Kaiser must develop an overview member rights policy that describes the rights afforded to CHP+ members and includes all rights defined in State and federal requirements.		
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A4—3.1.1.1.1	The member rights are outlined in the Provider Manual which each KP affiliated provider receives. There is a section referring to the way in which we treat our members that exists in the Principles of Responsibility which each Kaiser Permanente employee receives upon their employment with Kaiser Permanente. Documents: 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 182-188 53. CHP+ EOC- pg 40 61. Documentation_Affiliated Provider Letter 2015- Manual update pg 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records	The member's EOC, the Provider Manual and KP.org all outline each of the member's rights including each bullet point listed here in III-3. Documents: 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 185-187 *53. CHP+ EOC- pg 40 55. Principles of Responsibility_Kaiser Permanente Code of conduct- pg 7 and 12 50. Policy CO.RCO.PRIV.14 Minimum Necessary 62. Policy CO.RCO.PRIV.2 Amendment of PHI - Member and Patient Requests 6. Written and Verbal Translation Interpretation Services Policy and Procedure pg 1-10 26. Special Communications Needs P&P- PG 1-11 Onsite documents reviewed by HSAG:	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. *42CFR438.100(b)(2) and (3)* Contract: Exhibit A4—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.2	67. Affiliated Provider Manual Member Resource Guide Kp.org	
Findings: The member rights outlined in various member and provider materials were inconsistent and incomplete. The EOC did not address the right to receive information in a manner appropriate to the member's condition and ability to understand; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; the right to request amendment of medical records; or the right to be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. The member resource guide, provider manual, and affiliated provider manual did not address the member's right to obtain family planning services from any duly licensed provider in or out of network without a referral. The list of member rights on the kp.org website was different from the rights outlined in Kaiser's other documents. HSAG noted that the language describing member rights in the member resource guide, provider manual, and affiliated provider manual may be more member-friendly than the language used in the EOC and encouraged Kaiser to consider using this language in the EOC, as appropriate. HSAG recommends that Kaiser consider using consistent language to describe rights throughout their documents.		
Required Actions: Kaiser must revise documents to include all member rights outlined in the requirement and as noted in the *Findings*. Kaiser must ensure that any other documents, including those on kp.org, that reference or describe member rights are revised to be inclusive of all rights described by 42CFR438.100(b)(2) and (3) and CHP+ contract Exhibit A4.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A4—3.1.1.1.7	The EOC and Provider Manual both outline that the member is free to exercise his/her rights without adverse effects. Documents: 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 185-187 *53. CHP+ EOC- pg 40	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	Each federal and State law is addressed in one of the P&Ps attached in regards to Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. Documents: 63. ADA_CO201 ADA Nondiscrimination PG 1 64. KPCO ADA Compliance Site Link pg 1 65. KPCO ADA Compliance P&P Site Link pg 1 53. CHP+ EOC- pg 38 55. Principles of Responsibility_Kaiser Permanente Code of conduct- pg 28-29 149. ADA_CO202_Weight Measurement pg 1-28 150. ADA_CO203_Exam Room Access pg 1-28 151. ADA_CO204_MediaCommunications pg 1 152. ADA_CO205_AuxiliaryAides pg 1-4 153. ADA_CO206_AlternativeFormats pg 1-2 154. ADA_CO207_ServiceAnimals pg 1-5	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	3

Total Score ÷ Total Applicable	=	60%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. ◆ The Contractor's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of participating providers. NCQA CR1 CHP+ Contract: Exhibit A4—3.2.1.1; 3.2.1.3	This document identifies our policy and authority regarding credentialing, and lists the providers and heath care professionals covered by the policy. See identified section. Documents: 98. CR108 Purpose of Credentialing: Authority for Credentialing Policies & Procedures pages 1-2 Section I., A.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavior health provider.) *42CFR438.214(a)* NCQA CR1—Element A1	This document identifies our policy and authority regarding credentialing, and lists the providers and heath care professionals covered by the policy. See identified section. Documents: 98. CR108 Purpose of Credentialing: Authority for Credentialing Policies & Procedures pages 1-2 Section I., A.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.B. The verification sources used. NCQA CR1—Element A2	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 2-4 Section I., B. This document identifies the verification sources used during the initial credentialing process. See identified section. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 2-4 Section I., B.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	This document identifies the verification sources used during the recredentialing process. See identified section.	
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 1-4 Section I., A & B. This document identifies the criteria used during the initial credentialing process. See identified section. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 1-4 Section I., A & B. This document identifies the criteria used during the recredentialing process. See identified section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 4-5 Section I., C This document describes the elements considered in the decision making process during the initial credentialing process. See identified section. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 4-5 Section I., C This document describes the elements considered in the decision making process during the recredentialing process. See identified section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 4-5 Section I., C This document describes elements of the initial credentialing file. See identified section. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 4-5 Section I., C This document describes the elements of the recredentialing file. See identified section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 4-5 Section I., C This document describes delegation of initial credentialing. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 4-5 Section I., C This document describes delegation of recredentialing. 118. CR112 Affiliated Practitioner Credentialing: Delegated/Non-Delegated/Facility-Based Policies & Procedures pages 1-6 Section I., II. This document gives policies and procedures associated with delegation/non delegation for affiliated practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	98. CR108 Purpose of Credentialing: Authority for Credentialing Policies & Procedures pages 4-5 Section I., G. 1 & 2 This document gives the current nondiscrimination policy statement for both credentialing and recredentialing. 119. CR121 Annual Non-discrimination Report 2015 pg 1 This document presents the results of the Credentialing Department's review of all providers approved or not approved during the previous year to verify there is no evidence of discrimination. The report is then reviewed by the Credentialing Committee. This report is prepared in February of each year and reviews providers undergoing credential or recredentialing from the previous calendar year. 120. CR202 Credential Committee Minutes Feb 2015 Section C., 2. Page 24 This document presents the minutes of the Credentialing Committee meeting that included the review of the Annual Non-discrimination Report for 2015 (reporting on activity in calendar year 2014). Onsite documents reviewed by HSAG: Annual non-discrimination report for 2015	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	This document describes the policies related to employee access to the credentialing file, provider access to their own credentialing file, procedures for maintaining the confidentiality of the file and the provider's rights to notification of status. See indicated sections. Documents: 121. CR109 Access & Confidentiality of Information Policies & Procedures page 2 Section II. A.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 6 Section I., D. This document describes the policy for notifying the provider of the credentialing committee's decision for the initial credentialing process. See indicated section. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 5 Section I., D. This document describes the policy for notifying the provider of the credentialing committee's decision for the recredentialing process. See indicated section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	This document specifies the roles of the co-chairs of the Credentialing Committee. See identified section. Documents: 98. CR108 Purpose of Credentialing: Authority for Credentialing Policies & Procedures pages 3 Section II., B.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	122. CR120 Confidentiality and Nondiscrimination Agreement pg 1 This document describes the agreement to maintain confidentiality of information obtained in the credentialing/recredentialing process. 121. CR109 Access & Confidentiality of Information Policies & Procedures pages 1, 2 Section I., A. & B.; Section II., B.; and Section III, A., B., & C.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	This document describes the policies related to employee access to the credentialing file, access by external parties, provider access to their own credentialing file, procedures for maintaining the confidentiality of the file. See indicated sections	
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	123. CR 117 Reconciliation Report 2014 pg 1-4 This report provides a reconciliation between credentialing data and provider directories and member materials. This reconciliation is performed each year and the 2015 report in process at this time. Onsite documents reviewed by HSAG: 7204-20: Practitioner Reconciliation Process for Practitioner Directories and other Member Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	124. CR119 Colorado Health Care Professional Credentials Application (initial/recred) page 23 #12 This document contains a notification to providers of their right to review information. See identified section. 121. CR109 Access & Confidentiality of Information Policies and Procedures page 2, Section II., B. This policy specifies the provider's rights to review information in his/her own credentialing file. See identified section. Onsite documents reviewed by HSAG: Initial affiliate request for credentialing letter	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.N. The right to correct erroneous information. NCQA CR1—Element B2	124. CR119 Colorado Health Care Professional Credentials Application (initial/recred) page 23 #12 This document contains a notification to providers of their right to correct erroneous information. See identified section. 121. CR109 Access & Confidentiality of Information Policies and Procedures page 2, Section II., C. This policy specifies the provider's right to correct inaccurate information in his/her own credentialing file. See identified section. Onsite documents reviewed by HSAG: Initial affiliate request for credentialing letter	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	124. CR119 Colorado Health Care Professional Credentials Application (initial/recred) page 23 #12 This document contains a notification to the provider of their right to receive the status of the application. See identified section. 121. CR109 Access & Confidentiality of Information Policies and Procedures page 3, Section IV., A. This policy specifies the provider's right to be notified of the status of their application. See identified section. Onsite documents reviewed by HSAG: Initial affiliate request for credentialing letter	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR6—Element A	99. CHP CR 606 Ongoing Monitoring of Practitioner Complaints pg 1-11 This document describes the monitoring of practitioner complaints. 100. CHP CR 607 Delegated and Non Delegated Reports pg 1-14 101. CHP CR 608 KPNQC Complaints Referred to Quality from Member Services pg 1-3, 7-11 This document describes the handling of complaints referred to quality from member services providing a monitoring of complaints. 102. CHP CR 609 Regional Semi-Annual Complaints Review Process pg 1-3 103. CHP CR 700 PPRO pg 1-18 104. CHP CR 701 KPNQC Peer Review Policy pg 1-20 67. CHP QI205- Affiliated Provider Manual 125. CR611 Identifying and Responding to Ineligible Individuals and Entities pg 1-5 135. CR611 Identifying and Responding to Ineligible Individuals and Entities Procedures pg 1-8 126. CR616 Ineligible Individuals and Entities Report pg 1-7 127. CR203 Credentials committee Minutes Feb 2015 133. CR204 Credentials Committee Minutes May 2015 134. CR205 Credential Committee Minutes July 2015 128. CR613 Monitoring and License Sanctions 2015 120. CR202 Credential Committee Minutes June 2015 136. CR206 Credential committee Minutes August 2015 Onsite documents reviewed by HSAG: Semi Annual Reports 02 01 2016	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	103. CHP CR 700 PPRO 104. CHP CR 701 KPNQC Peer Review Policy 106. CHP CR 702 Practitioner Notification Letter Template 107. CHP CR 703 Practitioner Appeals Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR7—Elements A2 and B	103. CHP CR 700 PPRO 104. CHP CR 701 KPNQC Peer Review Policy This document describes the peer review policy and process. 107. CHP CR 703 Practitioner Appeals Policy This document describes the practitioner's appeal process for actions taken against the practitioner.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR7—Elements A3and C	103. CHP CR 700 PPRO 104. CHP CR 701 KPNQC Peer Review Policy 107. CHP CR 703 Practitioner Appeals Policy 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 176, 212-213	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	103. CHP CR 700 PPRO 104. CHP CR 701 KPNQC Peer Review Policy 106. CHP CR 702 Practitioner Notification Letter Template 107. CHP CR 703 Practitioner Appeals Policy 60. 2015 Provider Manual Final - Revision for CHP+ 12.22.2015 pg 176	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	98. CR108 Purpose of Credentialing Policy and Procedure pages 3-5 Section II A.- F. This document describes the credentialing committee and their responsibilities. 129. CR200 Credentials Committee Roster 2015 This document lists the members of the Credentialing Committee in 2015. 120. CR202 Credential Committee Minutes page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 10-11 Section II., A. – C. This section describes the process and committee responsibilities for reviewing practitioners not meeting thresholds during the initial credentialing process. See indicated sections. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 7 - 8 Section II., A. – C. This section describes the process and committee responsibilities for reviewing practitioners not meeting thresholds during the recredentialing process. See indicated sections.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 2-4 Section I., B. This document details the verification process for initial credentialing. See identified sections. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 2-4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification—board certification time limit is 180 calendar days). ◆ Work history (verification time limit is 365 calendar days; nonprimary verification is most recent five years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A	Section I., B. This document details the verification process for the recredentialing. See identified sections. Evidence available for review on site (file review)	
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= physician—0.5mil/1.5mil; facility—0.5mil/3mil).	124. CR119 Colorado Health Care Professional Credentials Application This is the application completed by practitioners for both initial credentialing and recredentialing. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ The correctness and completeness of the application. NCQA CR3—Element C CHP+ Contract: Exhibit A4—3.2.2.1.1; 3.2.2.1.2		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	116. CR110 Initial Practitioner credentialing Policies & Procedures pages 2-3 Section I., B. 1.-5., 8. This document describes sanction activities. See identified sections. 117. CR111 Practitioner Recredentialing Policies & Procedures pages 2-4 Section I., B. 1.-5., 7. This document describes sanction activities. See identified sections. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	108. CHP CR 500 PP Evaluation of KP Practitioner Sites 109. CHP CR 501 PP Evaluation of Affiliated Practitioner Sites 110. CHP CR 502 Semi Annual Complaint reports 111. CHP CR 504 Guidelines for Health Records 112. CHP CR 505 Guidelines for Behavioral Health Records	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds.	108. CHP CR 500 PP Evaluation of KP Practitioner Sites 109. CHP CR 501 PP Evaluation of Affiliated Practitioner Sites 110. CHP CR 502 Semi Annual Complaint reports 113. CHP CR 503 Medical Office Complaint_Redacted	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B		
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	117. CR111 Practitioner Recredentialing Policies & Procedures pages 1 Section I. This document specifies the timing of recredentialing. See identified section. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document describes policy for credentialing for affiliated organizational providers. 115. CHP CR 802 NTS COE Credentials Validation policy This document contains the credentialing validation policy for organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.B. The Contractor confirms—initially and at least every three years— that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This policy specifies verification of accreditation for organizational providers. 115. CHP CR 802 NTS COE Credentials Validation policy This document contains the credentialing validation policy for organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document specifies the evaluation of affiliated organizational providers, including timing of recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document specifies sources for the evaluation process for organizational providers. 115. CHP CR 802 NTS COE Credentials Validation policy This document contains the credentialing validation policy for organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document covers the policy and procedure related to quality assessment for organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document describes the evaluation process for affiliated organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR8—Element B	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document specifies the evaluation policy and procedure for affiliated organizational providers. 115. CHP CR 802 NTS COE Credentials Validation policy This document contains the credentialing validation policy for organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR8—Element C	114. CHP CR 800 PP Eval of Affiliated Organizational Provider Care Services This document specifies the evaluation policy and procedure for affiliated organizational providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
15. The Contractor has documentation that it has assessed contracted medical healthcare (organizational) providers. NCQA CR8—Element D	115. CHP CR 802 NTS COE Credentials Validation policy This document contains the credentialing validation policy for organizational providers. 105. CHP CR 801 Organizational Credentialing Spreadsheet	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element E	105. CHP CR 801 Organizational Credentialing Spreadsheet	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	130. CR905 University Physicians Inc. Credentialing Delegation Agreement 2015 This document contains the 2015 delegation agreement with specified organizational provider which describes the required activities. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	130. CR905 University Physicians Inc. Credentialing Delegation Agreement 2015 This document contains the agreed upon activities, responsibilities, reporting, and remediation with specified organizational provider. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B	Not applicable HSAG onsite review: Evidence of HIPAA-compliant Business Associate Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	130. CR905 University Physicians Inc. Credentialing Delegation Agreement 2015 This document contains the agreed upon decision making rights of the KP in relation to the specified organizational provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	Not Applicable	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	131. UPI Delegation Audit 2015 This document contains the results of the most recent audit of credentialing files. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	131. UPI Delegation Audit 2015 This document contains the results of the most recent audit of credentialing files. Evidence available on site (file review)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	132. CR904 University Physicians Inc. Semi Annual Delegation reports 2014-2015 This document contains the most recent delegation reports which are completed on a semi-annual basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	132. CR904 University Physicians Inc. Semi Annual Delegation reports 2014-2015 This document contains the most recent delegation reports which are completed on a semi-annual basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	47	X	1.00	=	47
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	1
Total Applicable		=	47	**Total Score**		=	47

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A4—2.9.1	Quality assessment and improvement tis the key function of the KPCO Integrated Patient Care Quality Program. The documents below describe the program and provide example minutes and metrics review. Documents: 38. 2015 KPCO Integrated Patient Care Quality Program Description- pg 78 72. 2015 Pediatric Quality Dashboard Metrics_FinalV3_for PC Communications- pg 1-2 71. Example of PC Dashboard metrics –pg 1 60. 2015 Provider Manual Final pgs 202 (SQRMC Program Description – Medical Group Quality Assurance and Improvement Program) 73. 2014 Program Evaluation Executive Summary_FINAL_SQRMC Approved 4.2.2015 pg 1-3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A4—2.9.4.4.1	Utilization Management is reviewed as part of the IPCQ and SQRMC Programs. Documents: 38. 2015 KPCO Integrated Patient Care Quality Program Description- section 10- pg 63-65 73. 2014 Program Evaluation Executive Summary_FINAL_SQRMC Approved 4.2.2015 pg 1-3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs. *42CFR438.240(b)(4)* Medicaid Contract: Exhibit A—2.7.2.4.4 CHP+ Contract: Exhibit A4—None	The documents below describe evaluations of quality and various interventions across several service-delivery areas within the organization. Documents: 137. QI1024 - Opportunity number 4- SNF Discharge Medication Standardization- pg 1-4 138. QI1023 - Opportunity number 3- Cont and Coord of Care- Complex Care Home Rounding- pg 1-4 139. QI1022 - Opportunity number 2- Cont and Coord of Care-	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	Implementation of PACT visit- pg 1-6 140. QI1021 - Opportunity number 1- Cont and Coord of Care- LACE Scoring- pg 1-4 141. QI 1116 Exchange of Information- Activity-Cont and Coord of Care-Exchange of Info- pg 1-10 142. QI1102 Behavioral Medicine Specialist Services Evaluation Factor 4- pg 1-14 143. QI1104 ADHD Initiation Phase Factor 2- pg 1-8 144. QI1113 IPV Prevention Initiative Factor 5- pg 1-13 145. QI1110 Special Needs of Members with Severe and Persistent Mental Illness Factor 6- pg 1-22 148. QI1105 ADHD Continuation Phase Factor 3- pg 1-4 38. 2015 KPCO Integrated Patient Care Quality Program Description- pg 45-52	
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care. Contract: Exhibit A4—2.9.2.1.1	Included below are several example clinical guidelines which meet this standard, as well as documentation regarding the documentation of member conditions in Health Connect. Documents: 8. PCMH Comprehensive Health Assessment Documentation pg 1-8 76. Prenatal Services by Trimester_6-1-2015 pg 1-3 77. Nursing Protocol_OB_Rooming pg 1-6 78. Healthy Beginnings Prenatal newsletter pg 1-8 79. Healthy Beginnings_Postpartum pg 1-10 30. Referral Pathways for Developmental Delay and Autism- pg 1-4 80. Down's Syndrome_1-2014- pg 1-2 81. ADHD diagnosis- pg 1-2 27. PEDIATRIC AND ADOLESCENT PREVENTIVE MEDICINE RECOMMENDATIONS_October 2015- pg 1-3	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Findings: Kaiser demonstrated having adopted clinical guidelines for well-child care, prenatal services, and several special needs conditions applicable to CHP+ members. Kaiser also provided program descriptions and screen shots of documentation in the HealthConnect EMR of elements of the postpartum visit. While these documents *may* indicate that Kaiser had adopted clinical treatment guidelines for postpartum care, Kaiser did not provide actual postpartum clinical practice guidelines adopted through the Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC) process.		
Required Actions: Kaiser must adopt or provide evidence that the CKCN/GLC has adopted postpartum clinical treatment/practice guidelines.		
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A4—2.9.2.1.2	In addition to the clinical guidelines described in Standard 4 above, these documents specifically outline how guidelines are developed as well as how physicians may access continuing medical education. Documents: 82. Clinical Practice Guideline_P-P_KPCO- pg 1-11 83. Clinical_Library_P-P_KPCO- pg 1-6 84. Pediatric CME Support 2015 pg 1-2 85. Children, Adolescents and Adult Asthma Clinical Practice Guidelines- pg 1-3	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Kaiser had clinical practice guideline policies and procedures that described the role of the CKCN/GLC and defined comprehensive processes for the development, approval, and implementation of clinical practice guidelines in compliance with the requirements. During on-site interviews, staff stated that Kaiser monitors clinical evidence from reliable professional sources between guideline update cycles and generates interim alerts to providers as applicable; however, the policies stated and staff confirmed that clinical guidelines are formally reviewed and updated by committee every two years. (The CHP+ contract requires that guidelines be reviewed and updated annually.)		
Required Actions: Kaiser must ensure that clinical practice guidelines applicable to CHP+ members are reviewed and updated annually.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
6. The Contractor disseminates the guidelines to all affected providers, and upon request to members, the Department, other nonmembers, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A4—2.9.2.1.3	These documents describe how both Colorado Permanente Medical Group and external contracted providers are given access to the provider manual and clinical practice guidelines information. Documents: 89. HC Provider's Guide Version 1.3[1]- pg 18 90. Clinical Library Screen shot pg 1 60. 2015 Provider Manual Final pgs 51 61. Documentation_Affiliated Provider Letter 2015- Manual update pg 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A4—2.9.2.1.4	The Clinical Practice Guideline P-P describes the overall development of practice guidelines. The implementation of these guidelines as standard visit questions within the Health Connect "Smart Sets" will be available to review on site. Documents: 82. Clinical Practice Guideline_P-P_KPCO Examples of Smartsets are available on site	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractors quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS. Contract: Exhibit A4—2.9.4.1.1; 2.9.4.1.2; 2.9.4.2.1	The IPCQ program description describes how the organizations reviews HEDIS metrics and selects metrics for improvement. Documents: 38. 2015 KPCO Integrated Patient Care Quality Program Description- Pgs 15, 17, 22, 44, 76	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
Kaiser demonstrated ongoing calculation and analysis of numerous HEDIS measures for the entire Kaiser population. Various committees and program staff trended and reviewed applicable measures periodically and reported results to the Service Quality and Resource Management Committee (SQRMC). While some HEDIS measures were analyzed specifically for the pediatric population, few measures were trended and analyzed specific to the CHP+ line of business. Staff stated that CHP+ HEDIS measures were analyzed by the CHP+ management team, but the team maintained no documentation of such and did not report results or recommendations to the quality improvement oversight committee(s).

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Required Actions: Kaiser must document that it analyzes, responds to, and reports the results of CHP+ HEDIS measures to quality oversight committees.		
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A4—2.9.4.3.2	KP provides quarterly reporting to the CHP+ Contract Manager at Health Care Policy and Financing which includes monitoring of member enrollment, appeals and grievance data, etc. This data is monitored internally by KP prior to submission to the state. Documents: 36. KP CHP Quarterly Report Fiscal Q1 Jul-Sep 2015 KP FINAL pg 1-13	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *NCQA Member Satisfaction* report to the SCRMC documented results of member satisfaction surveys, the CAHPS survey, and grievance and appeal data for commercial and Medicare members but did not identify data specific to Kaiser's CHP+ or its pediatric population. The *CHP MCO – Quarterly Report* included data and analysis of disenrollments, grievances and appeals, quality of care (QOC) concerns, and provider network adequacy. Kaiser could not provide documentation that demonstrated review of CAHPS or other member satisfaction measures specific to the CHP+ population. During on-site interviews, staff members stated that the MCP management team reviewed and analyzed CHP+ CAHPS results, but the team maintained no documentation of the analysis and reported no results or recommendations to the quality improvement oversight committee(s).		
Required Actions: Kaiser must document that it analyzes, responds to, and reports to quality oversight committees the results of the CHP+ CAHPS and any other member satisfaction survey data applicable to CHP+ members.		
10. The Contractor investigates any alleged quality of care concerns. ◆ Upon request, the Contractor shall submit a letter (within 10 business days) to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue, the outcome of the review, and what action the Contractor intends to take with the providers involved. Contract: Exhibit A4—2.9.4.5.1; 2.9.4.5.2	KP investigates all alleged quality of care concerns through the Customer Experience Grievance process. Documents: 134. Customer Experience Grievance Process for CHP+Members and Medicaid Members P&P	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
11. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes: ▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI Program during the prior 12-month period. ◆ Upon request, this information shall be made available to providers and members at no cost. *42CFR438.240(e)(2)* Contract: Exhibit A4—2.9.4.7; 2.9.4.6.1	KP submits the annual Quality Improvement Workplan to the Health Care Policy & Financing CHP+ Contract Manager annually. In addition, quality improvement projects are reported up through IPCQ and SQRMC processes as described in the IPCQ program description. Documents: 159. 20151014 2015-16 CHP Quality Improvement Work Plan FINAL 137. QI1024 - Opportunity number 4- SNF Discharge Medication Standardization- pg 1-4 138. QI1023 - Opportunity number 3- Cont and Coord of Care- Complex Care Home Rounding- pg 1-4 139. QI1022 - Opportunity number 2- Cont and Coord of Care- Implementation of PACT visit- pg 1-6 140. QI1021 - Opportunity number 1- Cont and Coord of Care- LACE Scoring- pg 1-4 141. QI 1116 Exchange of Information- Activity-Cont and Coord of Care- Exchange of Info- pg 1-10 142. QI1102 Behavioral Medicine Specialist Services Evaluation Factor 4- pg 1-14 143. QI1104 ADHD Initiation Phase Factor 2- pg 1-8 144. QI1113 IPV Prevention Initiative Factor 5- pg 1-13 145. QI1110 Special Needs of Members with Severe and Persistent Mental Illness Factor 6- pg 1-22 148. QI1105 ADHD Continuation Phase Factor 3- pg 1-4 38. 2015 KPCO Integrated Patient Care Quality Program Description- pg 45-52 147. QI1106 Composite Document KFHPC and VO Collaboration 2013 through 2015 38. 2015 KPCO Integrated Patient Care Quality Program Description- pg 15	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Findings: Kaiser produced an annual *Quality, Service & Resource Stewardship Program Evaluation* report for the SCRMC that included program results for the entire Kaiser population and that addressed many, but not all, required elements defined in the CHP+ contract. In addition, most results included in the report were applicable to the Medicare and commercial Kaiser membership and did not identify results specifically associated with the CHP+ and/or pediatric population. Although HSAG acknowledges that analysis and interventions applicable to the entire Kaiser membership may also apply to the CHP+ members, Kaiser did not produce a CHP+ annual report that included the elements required in the CHP+ contract. The annual *Quality Improvement Work Plan and Quality Assessment and Performance Improvement Project Status Report* submitted to the Department did not sufficiently address the annual QAPI report requirements.		
Required Actions: Kaiser must implement a process for evaluating the effectiveness of the QAPI program for CHP+ members and produce an annual CHP+ QAPI report that addresses all CHP+ requirements defined in section 4.7.2.1 of Kaiser's contract with the Department, including preventive care (e.g., HEDIS) results and goals, results of performance improvement projects (PIPs), results of member satisfaction surveys (e.g., CAHPS), detailed findings of program impact and techniques to improve performance, and an assessment of the overall effectiveness of the QAPI program.		
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data, including, but not limited to, information on utilization, grievances and appeals, encounters, and disenrollment. *42CFR438.242(a)* Contract: Exhibit A4—2.9.4.10.1	KP uses the HealthTrac database to combine clinical information, membership demographics, and communications with members in order to integrate data for care management and reporting needs. Documents: 95. guidelines_for_health_records_2014_5_14_ 4332_544 94. HealthTrac data flow- pg 1 158. KP HealthConnect _ Overview	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A4—2.9.4.10.2	HealthConnect captures data related to providers, members, and the services they receive. These documents describe HealthConnect and also ways in which member and provider data may be used and shared. Documents: 158. KP HealthConnect _ Overview 95. guidelines_for_health_records_2014_5_14_ 4332_544, pg 8 94. HealthTrac data flow- pg 1 8. PCMH Comprehensive Health Assessment Documentation pg 1-8 160. Policy CO.RCO.PRIV.6 Facility Directories - Uses and Disclosures of Protected Health Information	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* CHP+ Contract: None	Health information is collected through HealthConnect. The documents below describe the program overall and provide some detail regarding maintaining the validity of clinical data. Printouts from the interactive HealthConnect site have been provided, additional walkthrough of the website will be available onsite. http://insidekp.kp.org/kphealthconnect/overview/index.htm Documents: 156. KP HealthConnect _ Clinical Content Harvesting Strategy 157. KP HealthConnect _ Clinical Content 158. KP HealthConnect _ Overview	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor submits immunization information for all covered members to the Colorado Immunization Information System (CIIS) monthly. Contract: Exhibit A4—2.9.4.10.6	Member Immunization Data is submitted monthly to the state. The attached process flow shows the various data systems used to create the report. Documents: 133. CIIS Immunizations Feed Process	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	10

Total Score ÷ Total Applicable	=	67%

Appendix B. Record Review Tools for Kaiser Permanente Colorado

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Kaiser Permanente Colorado

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	February 8-9, 2016
Reviewer:	Katherine Bartilotta and Theresa Larsen
Participating Plan Staff Member:	Beth Champlin

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	PA-C	PA-C	LAC	MD	MD	MD	MD	MD	LCSW
Application/Attestation Date	03/05/2015	12/13/2014	07/29/2014	12/10/2014	06/22/2015	12/03/2014	03/12/2015	03/13/2015	11/16/2014	01/23/2015
Credentialing Date (Committee/Medical Director Approval Date)	07/16/2015	02/19/2015	01/22/2015	01/12/2015	10/01/2015	05/21/2015	08/05/2015	07/16/2015	04/16/2015	03/22/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**9**	**9**	**8**	**8**	**9**	**9**	**9**	**9**	**9**	**8**
# Compliant elements	**9**	**9**	**8**	**8**	**9**	**9**	**9**	**9**	**9**	**8**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Record Review Score					**Total Applicable: 87**	**Total Compliant: 87**	**Total Percentage: 100%**

Comments:

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Kaiser Permanente Colorado

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	February 8-9, 2016
Reviewer:	Katherine Bartilotta and Theresa Larsen
Participating Plan Staff Member:	Beth Champlin

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	PT	MD	MD	MD	NP	PA-C	MD	MD	PhD
Application/Attestation Date	06/04/2015	08/28/2015	03/31/2015	09/15/2015	08/25/2015	08/10/2015	11/25/2014	07/23/2015	05/20/2015	02/06/2015
Last Credentialing/Recredentialing Date	08/01/2012	11/05/2012	07/09/2012	04/25/2013	02/28/2013	12/20/2012	02/16/2012	10/01/2012	09/10/2012	03/05/2012
Recredentialing Date (Committee/Medical Director Approval Date)	08/27/2015	10/05/2015	06/01/2015	12/17/2015	12/17/2015	11/02/2015	02/02/2015	08/31/2015	08/03/2015	03/02/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**9**	**7**	**9**	**9**	**8**	**8**	**9**	**9**	**9**	**7**
# Compliant elements	**9**	**7**	**9**	**9**	**8**	**8**	**9**	**9**	**9**	**7**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Record Review Score					**Total Applicable: 84**		**Total Point Score: 84**		**Total Percentage: 100%**	

Comments:

Appendix C. Site Review Participants for Kaiser Permanente Colorado

Table C-1 lists the participants in the FY 2015–2016 site review of **Kaiser**.

Table C-1—HSAG Reviewers and Health Plan Participants

HSAG Review Team	Title
Theresa Larsen	Associate Director
Katherine Bartilotta, BSN	Senior Project Manager
Kaiser Participants	**Title**
Adam Stauthamer	Manager, Regulatory Oversight and Quality Improvement
Annie Lee	Director, Medicaid & Charitable Coverage Programs
Beth Anderson	Quality Assurance Auditor
Beth Champlin	Credentialing Manager
Chara Hoover	Accreditation Specialist
Elaine Gatto	Credentialing Programs Manager
Herb Dean	Assistant Director, Compliance
Irma Smith	Senior Manager, Palliative Care & Hospice, and Pediatric Care Coordination
Jeannie Hoover	Senior Compliance Manager
Jonathan Sweeney	Clinical Library Content Coordinator
Kathy Nylin	Quality Review Coordinator, Facility Credentialing
Kathy Lovick	Senior Project Manager—Quality, Risk, and Patient Safety
Kim Rundle	Pediatric Care Coordinator
Margaret Fitzhugh	Counsel – Government Programs Practice Group, Legal Department
Robin Dam	Compliance Auditor
Sean-Casey King	Senior Manager, MCP Business Operations
Sheena Mile	Project Manager, MCP
Susan Pharo	Physician and Medical Director, MCP
Tonya Bruno	Senior Outreach and Retention Specialist, MCP
Department Observers	**Title**
Jerry Ware	Quality and Health Improvement Unit
Teresa Craig	Contract and Program Manager, MCO and SMCN

Appendix D. Corrective Action Plan Template for FY 2015–2016 *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

For this step,	HSAG completed the following activities:
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, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* Kaiser

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary.	Kaiser demonstrated that pediatric members receive a thorough needs assessment that is documented in the HealthConnect EMR. Although the EMR also documented an associated set of interventions in response to the assessment, Kaiser was unable to demonstrate that the treatment plan included the required elements—treatment objectives/goals, planned follow-up, or monitoring of outcomes of the treatment plan. In addition, provider communications (e.g., provider manual) did not address the requirement for a treatment plan that included the specified elements.	Kaiser must provide evidence that the member treatment plan includes treatment objectives, treatment follow-up, monitoring of outcomes, and revision as necessary.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.	The pediatric care coordination intake assessment and some HealthConnect protocols (smart sets) applicable to select populations of members (e.g., members transitioning care settings) included statements certifying that the member/parent participated in the assessment and agreed to the care coordination plan. However, records of the general population of CHP+ members (i.e., those not engaged in special programs) contained no similar documentation. Kaiser had no provider protocols or instructions to require that members/family members be involved in treatment planning and consent.	Kaiser must implement procedures to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
10. The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care.	Kaiser had no policies and procedures that addressed this requirement; however, the CHP+ EOC stated that Kaiser will provide continuity of care (defined as "transitional care and treatment received from non-plan providers") for members who meet certain eligibility criteria and who submit a complete application for continuity of care services. The listed eligibility criteria were unclear as to whether continuity of care applies to newly enrolled members involved in an ongoing course of treatment. The EOC also stated the transition period for continuity of care "will not exceed a period of sixty (60) days" (the CHP+ requirement is explicitly 60 days). The EOC did not inform members that *new* members involved in an ongoing course of treatment may continue services for the required time fames outlined in the requirement. During on-site interviews, staff members further stated that the Kaiser utilization management team would determine whether the member's needs could be met within the Kaiser provider network before approving transitional or continuing care from a non-plan provider, which is in conflict with CHP+ requirements.	Kaiser must provide for and clearly inform newly enrolled members with special healthcare needs involved in ongoing courses of treatment that they may continue care for 60 days with the current provider, receive continued ancillary services for 75 days, and continue (in the second or third trimester of pregnancy) with the current provider until completion of postpartum care. Kaiser must also demonstrate that procedures allow for continuity of care for newly enrolled members, as outlined in the requirement.
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:		

Table D-2—FY 2015–2016 Corrective Action Plan *for* Kaiser

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
1. The Contractor has written policies and procedures regarding member rights.	Although Kaiser had several documents that listed member rights, Kaiser had no member rights policy.	Kaiser must develop an overview member rights policy that describes the rights afforded to CHP+ members and includes all rights defined in State and federal requirements.
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 IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Obtain family planning services from any duly licensed provider in or out of network without a referral. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.	The member rights outlined in various member and provider materials were inconsistent and incomplete. The EOC did not address the right to receive information in a manner appropriate to the member's condition and ability to understand; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; the right to request amendment of medical records; or the right to be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. The member resource guide, provider manual, and affiliated provider manual did not address the member's right to obtain family planning services from any duly licensed provider in or out of network without a referral. The list of member rights on the kp.org website was different from the rights outlined in Kaiser's other documents.	Kaiser must revise documents to include all member rights outlined in the requirement and as noted in the *Findings*. Kaiser must ensure that any other documents, including those on kp.org, that reference or describe member rights are revised to be inclusive of all rights described by 42CFR438.100(b)(2) and (3) and CHP+ contract Exhibit A4.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care.	Kaiser demonstrated having adopted clinical guidelines for well-child care, prenatal services, and several special needs conditions applicable to CHP+ members. Kaiser also provided program descriptions and screen shots of documentation in the HealthConnect EMR of elements of the postpartum visit. While these documents *may* indicate that Kaiser had adopted clinical treatment guidelines for postpartum care, Kaiser did not provide actual postpartum clinical practice guidelines adopted through the Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC) process.	Kaiser must adopt or provide evidence that the CKCN/GLC has adopted postpartum clinical treatment/practice 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:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually.	Kaiser had clinical practice guideline policies and procedures that described the role of the CKCN/GLC and defined comprehensive processes for the development, approval, and implementation of clinical practice guidelines in compliance with the requirements. During on-site interviews, staff stated that Kaiser monitors clinical evidence from reliable professional sources between guideline update cycles and generates interim alerts to providers as applicable; however, the policies stated and staff confirmed that clinical guidelines are formally reviewed and updated by committee every two years.	Kaiser must ensure that clinical practice guidelines applicable to CHP+ members are reviewed and updated annually.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractors quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS.	Kaiser demonstrated ongoing calculation and analysis of numerous HEDIS measures for the entire Kaiser population. Various committees and program staff trended and reviewed applicable measures periodically and reported results to the Service Quality and Resource Management Committee (SQRMC). While some HEDIS measures were analyzed specifically for the pediatric population, few measures were trended and analyzed specific to the CHP+ line of business. Staff stated that CHP+ HEDIS measures were analyzed by the CHP+ management team, but the team maintained no documentation of such and did not report results or recommendations to the quality improvement oversight committee(s).	Kaiser must document that it analyzes, responds to, and reports the results of CHP+ HEDIS measures to quality oversight committees.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information.	The *NCQA Member Satisfaction* report to the SCRMC documented results of member satisfaction surveys, the CAHPS survey, and grievance and appeal data for commercial and Medicare members but did not identify data specific to Kaiser's CHP+ or its pediatric population. The *CHP MCO – Quarterly Report* included data and analysis of disenrollments, grievances and appeals, quality of care (QOC) concerns, and provider network adequacy. Kaiser could not provide documentation that demonstrated review of CAHPS or other member satisfaction measures specific to the CHP+ population. During on-site interviews, staff members stated that the MCP management team reviewed and analyzed CHP+ CAHPS results, but the team maintained no documentation of the analysis and reported no results or recommendations to the quality improvement oversight committee(s).	Kaiser must document that it analyzes, responds to, and reports to quality oversight committees the results of the CHP+ CAHPS and any other member satisfaction survey data applicable to CHP+ members.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
11. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes: ▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI Program during the prior 12-month period. ◆ Upon request, this information shall be made available to providers and members at no cost.	Kaiser produced an annual *Quality, Service & Resource Stewardship Program Evaluation* report for the SCRMC that included program results for the entire Kaiser population and that addressed many, but not all, required elements defined in the CHP+ contract. In addition, most results included in the report were applicable to the Medicare and commercial Kaiser membership and did not identify results specifically associated with the CHP+ and/or pediatric population. Although HSAG acknowledges that analysis and interventions applicable to the entire Kaiser membership may also apply to the CHP+ members, Kaiser did not produce a CHP+ annual report that included the elements required in the CHP+ contract. The annual *Quality Improvement Work Plan and Quality Assessment and Performance Improvement Project Status Report* submitted to the Department did not sufficiently address the annual QAPI report requirements.	Kaiser must implement a process for evaluating the effectiveness of the QAPI program for CHP+ members and produce an annual CHP+ QAPI report that addresses all CHP+ requirements defined in section 4.7.2.1 of Kaiser's contract with the Department, including preventive care (e.g., HEDIS) results and goals, results of performance improvement projects (PIPs), results of member satisfaction surveys (e.g., CAHPS), detailed findings of program impact and techniques to improve performance, and an assessment of the overall effectiveness of the QAPI program.
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 healthcare 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 email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards 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 lists of all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site review request. 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to CHP+ credentialing and recredentialing. ◆ 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 2015–2016 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.