CHP+

Child Health Plan *Plus*

Fiscal Year 2016–2017 Site Review Report

for

Kaiser Permanente Colorado

May 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply 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 (BBA), Public Law 105-33. 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 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. For each of the two standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 contains (as available) graphical representations of results for all standards across two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2016–2017 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 within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Kaiser Permanente Colorado** (**Kaiser**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	34	34	32	2	0	0	94%
II. Access and Availability	14	14	13	1	0	0	93%
Totals	**48**	**48**	**45**	**3**	**0**	**0**	**94%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	54	54	54	0	0	100%
Totals	**54**	**54**	**54**	**0**	**0**	**100%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

Kaiser submitted its *Quality Assessment and Performance Improvement Project Status Report And Quality Improvement Work Plan* and *2016 Integrated Patient Care Quality Program Description* to demonstrate that **Kaiser** ensures that services in sufficient amount, duration, and scope are provided to its CHP+ population. The two reports outlined ongoing quality studies, activities, and work plans, including related results. The reports allowed **Kaiser** opportunities to evaluate effectiveness of care provided and to identify areas wherein it may be able to impact provision of services to improve outcomes.

During the period in review, **Kaiser** maintained a comprehensive utilization management (UM) program. Staff members were able to competently describe the program in detail and communicate effectively to HSAG the process of criteria-based authorization review, which included registered nurse (RN) and medical doctor (MD) review when need indicated. Policies supplied for review aligned with the process described by staff. A sample of denial records reviewed by HSAG were found to consistently demonstrate the requirements for review and response to the CHP+ member and provider. The notice of action letters to the members included all required information.

Within its policies and procedures, **Kaiser** appropriately defines "emergency medical condition" and "emergency services." Provisions for emergency care are made to CHP+ members without prior authorization, and staff members stated that retrospective review is not conducted following emergency care.

Summary of Findings Resulting in Opportunities for Improvement

HSAG found that while the template language in the notice of action to members and additional appeals backer was considered to be within the generally accepted definition for ease of understanding, some wording might be considered borderline sixth grade reading level. **Kaiser** CHP+ members may benefit from a review of the language in these documents to help navigate the documents with clearer understanding. Some words and terms to consider replacing include any or all of "relevant, circumstances, adverse benefit determination, clinical situation," and "testimony."

Kaiser staff members should be aware that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all medical assistance programs and included the addition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-specific criteria. Therefore, HSAG recommends that **Kaiser** update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.

Summary of Required Actions

While **Kaiser** clearly addressed within its *Authorizations of Services* policy the extent to which it is responsible for covering services, it has not specified within policies and procedures the medical necessity criteria outlined in the State plan nor does **Kaiser** refer to another source to obtain these criteria. **Kaiser** must update UM policies and procedures to clearly define the medical necessity criteria outlined in the State plan as applicable to authorization decisions.

Kaiser's *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. However, the policy did not include reference to other notification time frame requirements applicable to Medicaid members, specifically:

- For service authorization decisions not reached within the required time frames on the date time frames expire.
- If the Contractor extends the time frame, no later than the date the extension expires.
- For denial of payment, at the time of any action affecting the claim.

Kaiser must update its policies and procedures to address all notification time frames applicable to members as outlined in the requirement.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

Kaiser provided its *Practitioner Availability and Sufficiency of Services* policy and its *Network Adequacy Report* as evidence that **Kaiser** maintained and monitored an appropriate and sufficient network of providers. On-site, **Kaiser** staff members were able to articulate in detail how the policy, adequacy report, and various other monitoring methods were used to evaluate the member population's service area and specific needs to ensure sufficient access and delivery of services.

Kaiser provided HSAG with applicable policies and procedures which evidenced access to care for: female members to women's health specialists, second opinions, and out-of-network providers in the event that a covered healthcare need could not be met within the network. **Kaiser** also provided evidence that out-of-network providers would not incur additional fees for members when those members are medically indicated and a like provider is not available from within the network.

Kaiser provided HSAG with its *National Diversity and Inclusion* policy which described **Kaiser** Foundation Hospitals'/**Kaiser** Foundation Health Plan, Inc.'s (**Kaiser** CHP+'s parent company's) focus on diversity and inclusion as core organizational values and key business strategy. HSAG found that **Kaiser** had in place mandatory diversity and cultural competency training for all employees upon hire, to be repeated annually. Additional training modules were mandatory, but only for specific providers; an

example was the *Leading in a Multicultural Environment* module, required for all new nurse managers. Other optional training modules were available. Topics for these modules covered inclusion, sensitivity and etiquette, and member engagement. During the on-site interview, staff members described their personal experiences taking part in the training modules. Descriptions included the value staff members found in the content provided, specifically noting the module titled *Unconscious Bias* and modules that included small group discussion sessions.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to access and availability.

Summary of Required Actions

During the on-site interview, **Kaiser** CHP+ staff members stated that practitioners make referrals to specialists within the KP provider network as needed to meet the needs of the members; however, for CHP+ members with special healthcare needs, **Kaiser** had no written procedures that address a process allowing direct access or standing referrals to specialists or for allowing members to use specialists as primary care providers (PCPs) when indicated by those members' health conditions. **Kaiser**'s policies and procedures must allow members with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or allow such members direct access or standing referrals to specialists.

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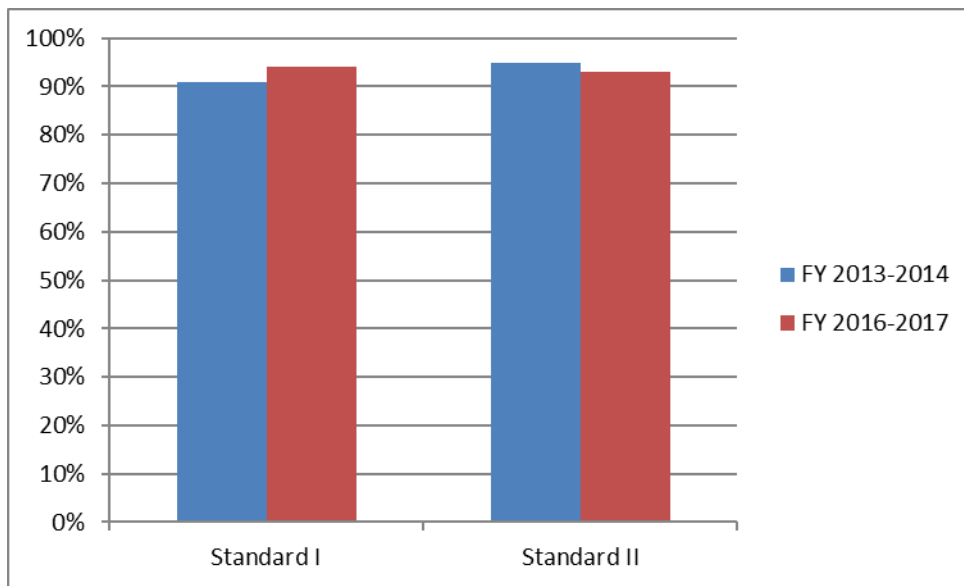
2. Comparison and Trending

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II 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.

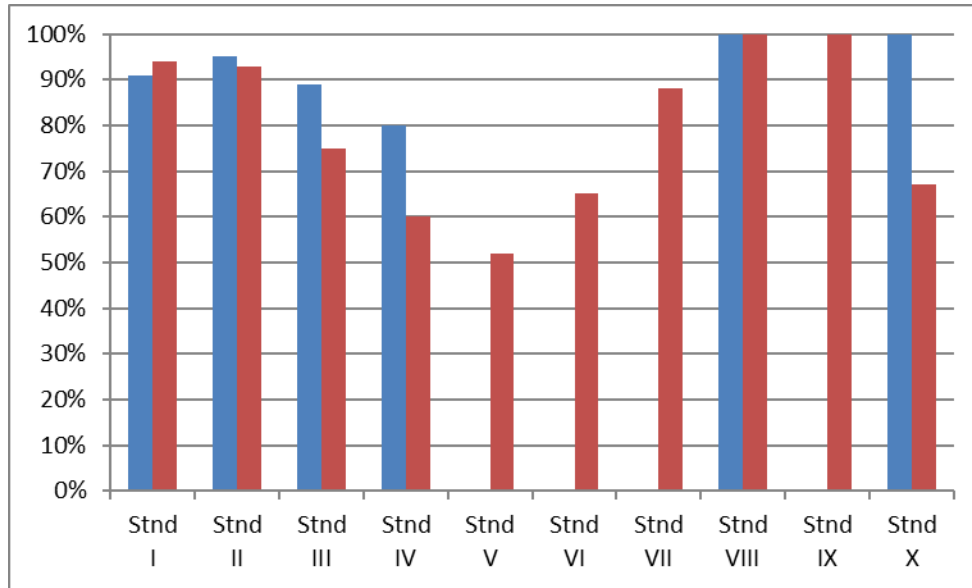
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past five years of compliance monitoring. The figure compares the score for each standard across two review periods, as available, 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 and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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	2016–17
I—Coverage and Authorization of Services		X			X
II—Access and Availability		X			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	

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials.

A sample of the health plan's administrative records related to CHP+ service and claims denials was reviewed to evaluate implementation of managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 site review, each health plan that received one or more *Partially Met* or *Not Met* scores 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

As a result of the FY 2015–2016 site review, **Kaiser** was required to address two *Partially Met* elements and one *Not Met* element in Standard III—Coordination and Continuity of Care, one *Partially Met* element and one *Not Met* element in Standard IV—Member Rights and Protections, and five *Partially Met* elements in Standard X—Quality Assessment and Performance Improvement.

Summary of Corrective Action/Document Review

Kaiser submitted its proposed CAP in June 2016. **Kaiser** submitted documents to demonstrate completion of the plan in July, September, November, and December 2016. As of February 2017, **Kaiser** had completed eight of the 10 required actions.

Summary of Continued Required Actions

As of March 2017, **Kaiser** had two outstanding FY 2015–2016 corrective actions. **Kaiser** must implement procedures to ensure that all CHP+ members and/or authorized family members are involved in treatment planning and consent to medical treatment. **Kaiser** must also ensure that all documents that reference or describe member rights are revised to be inclusive of all members. HSAG and the Department will continue working with **Kaiser** until all required actions are adequately addressed.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Amendment 6, Exhibit A-5—2.6.3	• **Quality Assessment and Performance Improvement Project Status Report And Quality Improvement Work Plan - Child Health Plan Plus (CHP+) Program** (20161230-KP_CHP+QAPI_FINAL.pdf). • **2016 Integrated Patient Care Quality Program Description** (2016-KP_IPCQ.pdf) – See Purpose and Goals, pg 10. These reports demonstrate that the Kaiser Permanente Colorado monitors the services provided to all our members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration, and scope no less than services provided to non-CHP+ recipients within the same area. *42 CFR 438.210(a)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.6.3.9	Except where required by the CHP+ contract, CHP members receive the same access to services in terms of timeliness, amount, duration and scope as members of other lines of business. • **2016 Program Description – Resource Stewardship / Utilization Management** (2016-KP_IPCQ.pdf) – See Section10—Resource Stewardship/Utilization Management Program, pgs 61-64. • **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. Utilization Management shall be conducted under the auspices of a qualified clinician. Contract: Amendment 6, Exhibit A-5—2.8.1.1	**2016 Program Description – Resource Stewardship / Utilization Management** (2016-KP_IPCQ.pdf) – See Section10—Resource Stewardship/Utilization Management Program. See highlighted section on pg 62.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-5—2.6.3.10	**Medical Necessity Criteria, Policy ID #: 6891-14** (MedicalNecessityCriteria16.pdf). See Policy Statement – demonstrates the guidelines for utilization management decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42 CFR 438.210(a)(3)(iii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.8.1.1	• **Medical Necessity Criteria, Policy ID #: 6891-14** (MedicalNecessityCriteria16.pdf). See Policy Statement – demonstrates limits based on medical necessity determinations. • **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, paragraph 2 and highlighted section on pg 3 – demonstrates review for medical necessity.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is consistent with the symptoms, diagnosis, and treatment of a member's medical condition. – Is widely accepted by the practitioner's peer group as effective and reasonably safe based upon scientific evidence.	• **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, paragraph 2 (highlighted); and • Last paragraph on pg 1: *Benefits are no more restrictive in amount, duration and scope than that used in the Medicare and State Medicaid program as indicated in state statutes and regulations and the State Plan for Senior Advantage, CHP+ and Access KP covered persons.*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Is not experimental, investigational, unproven, unusual, or uncustomary. – Is not solely for cosmetic purposes. – Is not solely for the convenience of the member, subscriber, physician, or other provider. – Is the most appropriate level of care that can be safely provided to the member. – Failure to provide the covered service would adversely affect the member's health. – When applied to inpatient care, "medically necessary" further means that covered services cannot be safely provided in an ambulatory setting. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—1.1.1.58	• **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf) Medically Necessary definition, pg 38 • **Medical Necessity Criteria, Policy ID #: 6891-14** (MedicalNecessityCriteria16.pdf). See Policy Statement, paragraph 1 – Demonstrates criteria applied to requested services.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While Kaiser clearly addressed the extent to which it is responsible for covering services within its *Authorizations of Services* policy, it has not specified within its policies and procedures the medical necessity criteria outlined in the State Medicaid Plan; nor did Kaiser refer to another source to obtain these criteria. In addition, Kaiser staff members should be aware that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, HSAG recommends that Kaiser update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.		
Required Actions: Kaiser must update its UM policies and procedures to clearly define the medical necessity criteria outlined in the State Medicaid Plan as applicable to authorization decisions.		
7. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-5—2.8.1.2	**Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Procedure to Implement Policy, pgs 4-6 – demonstrate process for requesting authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-5—2.8.1.3	**Monitoring of Reviewer Reliability, Policy ID #: 6891-15.** See Policy Statement. Demonstrates how Kaiser Permanente Colorado monitors staff for consistency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-5—2.8.1.3	• **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, pg 2, paragraph 1. Demonstrates process for physician consultation. • **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See Procedure to Implement Policy – 1. Pre-service, a. Urgent Care, 2 – demonstrates process for consulting with provider when necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor's UM Program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.1	• **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, pg 2, paragraph 1. Demonstrates process for seeking clinical expertise during decision making. • **Denial of Coverage, Policy ID #: 6891-12** (DenialofCoverage16.pdf) See Policy Statement, paragraph 3. Demonstrates process for seeking clinical expertise during decision making. • **Affirmation Statement for Board Certification, Policy ID #: 6891-02** (AffirmationStatementofBoardCertification16.pdf)**.** See Policy Statement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.3	• **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Procedure to Implement Policy, highlighted sections on pgs 5 and 6. Demonstrates authorization notification regarding amount, duration and scope. • **Denial of Coverage, Policy ID #: 6891-12** (DenialofCoverage16.pdf). See Policy Statement, pg 2, paragraph 2 (highlighted).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.1	**Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See highlighted section on pg 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)*	**Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See highlighted section on pg 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10CCR2505—10, Sec 8.209.4.A.3(c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2 and 2.8.1.3.3.2.1		
14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.1 Contract: Amendment 6, Exhibit A-5—2.4.3.1.6	• **Notice of Action – CHP+ Denial, Medical Necessity** (NOA_CHP+ Med Necessity Denial.pdf) • **Notice of Action – Benefit Denial with Appeal Rights** (NOA_CHP+Benefit Denial.pdf) • **CATLAR Notice of language assistance** (CATLARTaglines_CM_CO_2016_Ltr.pdf). Demonstrates state specific non-English language assistance letter added to all essential member communications.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it.	• **Denial of Coverage, Policy ID #: 6891-12** (DenialofCoverage16.pdf). See Policy Statement, pg 3, #1 (highlighted). • **Notice of Action – CHP+ Denial, Medical Necessity** (NOA_CHP+ Med Necessity Denial.pdf) • **Notice of Action – Benefit Denial with Appeal Rights** (NOA_CHP+Benefit Denial.pdf)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505—10, Sec 8.209.4.A.2 Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See highlighted section on pgs 5, 6 and 7. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See highlighted section on pg 5. • **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, pg 2, paragraph 4. Demonstrates once preauthorized, benefits cannot be retrospectively denied.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for CHP+ services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the timeframe, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211, 431.213,* and *431.214* 10CCR2505—10, Sec 8.209.4.A.3(a-c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		

Findings:
Kaiser's *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. Staff members stated that Kaiser does not terminate or reduce previously approved authorizations for members. However, the policy omitted reference to other notification time frame requirements applicable to Medicaid members, specifically:

- For service authorization decisions not reached within the required time frames on the date time frames expire.
- If the Contractor extends the time frame, no later than the date the extension expires.
- For denial of payment, at the time of any action affecting the claim.

Required Actions:

Kaiser must update its policies and procedures to address all notification time frames applicable to members as outlined in the requirement.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-5—2.8.1.3.3.2	**Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See #2 c on pg 3 and highlighted section on pg 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10CCR2505—10, Section 8.209.4.A.3(c)(i) Contract: Amendment 6, Exhibit A-52.8.1.3.3	**Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf). See #2 c on pg 3 (highlighted).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-5—2.8.1.1	**Denial of Coverage, Policy ID #: 6891-12** (DenialofCoverage16.pdf). See Policy Statement, pg 1, paragraph 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—1.1.1.28	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, paragraph 4, pgs 1-2. This document supplies the definition.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—1.1.1.29	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, highlighted section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.4	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, paragraphs 2 and 3, pg 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Contract: Amendment 6, Exhibit A-5—2.6.6.1.2	**Coverage of Emergency Services Policy ID #: 6891-03.** See paragraph 2, pg 2. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See highlighted sections on pgs 16 (for emergency services) and 17 (for urgent care).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor shall not require prior authorization for emergency services or urgently needed services. • The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.3	• **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See highlighted sections on pgs 16 (for emergency services) and 17 (for urgent care). • **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, paragraph 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #20 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition	• **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See highlighted sections on pg 16. Also see Definitions, Emergency Medical Condition (Emergency and Emergency Services on pg 38. • **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, paragraph 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
but the absence of immediate medical attention would ***not*** have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part. • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.3 and 2.6.6.1.4		
26. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.3.1, 2.6.6.6.2.1, and 2.6.6.1.6	• **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). #1 – Emergency Services on pg 16. Also see Definitions, Emergency Medical Condition (Emergency and Emergency Services on pg 38. • **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor will be responsible for emergency services: • When the primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions and procedures. • When the primary diagnosis is psychiatric in nature, even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: Amendment 6, Exhibit A-5—2.6.6.6.2.1.1–2	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.7	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.1.5	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown* Contract: Amendment 6, Exhibit A-5—1.1.1.69	• **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). #1 – Emergency Services, a. After Your Emergency is Stabilized (Post-Stabilization) on pg 16.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.4	• **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 16, #1 – Emergency Services, a. After Your Emergency is Stabilized (Post-Stabilization).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services.	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.5 and 2.6.6.4.1.6.1–3		
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer.	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.8.1–4		
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-5—2.6.6.4.1.7	**Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	34	**Total Score**		=	32

Total Score ÷ Total Applicable	=	94%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor's network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care physician (PCP) provider-to-members ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.5.10, 2.7.1.1.5, and 2.7.1.1.9	• **Practitioner Availability and Sufficiency of Services Policy Number: 7204-09** (Practitioner Availability and Sufficiency of Services_121316_Draft.pdf)**.** See 5.0 Provision on pg 3. This policy identifies how the company evaluates the availability of practitioners and provider performance to the standards. The process through which the company monitors availability is provided. Note: Currently in draft form due to updates. This is a current policy in use. • **Kaiser Permanente Colorado Denver Boulder Medicaid (CHP+ and Access KP Membership) Network Adequacy Report** (Medicaid_CHP+ Network Adequacy Analysis.pdf). See CHP+ results on pgs 9-14.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.7.1.3.1 and 2.7.1.1.3.1	• **Kaiser Permanente Colorado Denver Boulder Medicaid (CHP+ and Access KP Membership) Network Adequacy Report** (Medicaid_CHP+ Network Adequacy Analysis.pdf). See CHP+ results on pgs 9-14. • **CHP+ Membership and Provider Map.pdf** This document graphically displays member locations vs. practitioner and facility locations. • **Denver Boulder Locations.pdf** This document provides a map and the addresses of the Denver / Boulder Medical Office Buildings.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's healthcare specialist. *42 CFR 438.206(b)(2)* Contract: Amendment 6, Exhibit A-5—2.7.1.1.7	• **Denver/Boulder Member Resource Guide 2017** (cco_member_resource_guide.pdf). See Note under Find the Right Doctor for You. Female members may elect an OB / GYN as their PCP. Also see Specialty Care, pg 7. All members have access to specialty care, including obstetrics / gynecology. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 4, Getting a Referral, #2 Specialty Self Referral.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor allows persons with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Contract: Amendment 6, Exhibit A-5— 2.7.5.4	**Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See Find the Right Doctor for You on pg 6 and Specialty Care, pg 7. This provides information for selecting a PCP of the member's choosing. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 4, 1. Choosing Your Primary Care Plan Physician – explains the process for choosing a PCP based on a members health care needs. Also, Getting a Referral, #2 Specialty Self-Referral, describing self-referral to specialists.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, Kaiser CHP+ staff members stated that practitioners make referrals to specialists within the KP provider network as needed to meet the needs of the member; however, for CHP+ members with special healthcare needs, Kaiser had no written procedures that address a process allowing direct access or standing referrals to specialists or allowing use of specialists as PCPs when indicated by members' health conditions.		
Required Actions: Kaiser's policies and procedures must allow members with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or allow such members direct access or standing referrals to specialists.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-5—2.7.1.1.8	• **Denver/Boulder Member Resource Guide 2017** (cco_member_resource_guide.pdf). See pg 31, right column, last bullet – You have the right to a second opinion by a Kaiser Permanente physician. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 4, B. Getting a Referral, #3 Second Opinions – explains access to second opinions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-5—2.7.1.2	• **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 4, B. Getting a Referral, #1 Referrals (highlighted). • **Authorization of Services, Policy ID #: 6891-13** (Authorization ofServices16.pdf). See Policy Statement, pg 3, paragraph 1 for description of authorization process for contracted and non-contracted providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-5—2.7.1.2.2.1	**KFHP External Provider Contract Template** (KFHP Template_CO_Standard.pdf). See highlighted section 3.3 Member Hold Harmless on pg 9 and # 3 in Exhibit 3, pg 34. Providers may not charge the member more than their cost share amount for plan covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-5—2.6.3.1, 2.6.3.4, and 2.7.1.4.1.1	**CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 16, H. Emergency Services and Urgent Care, #1 Emergency Services, paragraph 2 explains 24/7 availability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other CHP+ providers. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-5—2.5.1	**Denver/Boulder Member Resource Guide 2017** (cco_member_resource_guide.pdf). See pg 7, Care Available to You. All services are available to all members. Hours of operations per facility are available at kp.org.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Within 48 hours for urgently needed services. • Within 30 calendar days for: – Non-emergent, non-urgent medical problems. – Non-urgent, symptomatic medical problems. – Non-symptomatic well-care physical examinations. *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-5—2.6.3.2 and 2.6.3.3.1–4	• **KFHP External Provider Contract Template** (KFHP Template_CO_Standard.pdf). See highlighted text on page 5. • **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07** (Access to Care Policy.2017.pdf). See Attachment A for all Accessibility of Services time standards. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 7, Appointment Scheduling Guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Within 14 calendar days for: – Diagnosis and treatment of a non-emergent, non-urgent substance use disorder. – Diagnosis and treatment of a non-emergent, non-urgent mental health condition. *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.2.5–6	• **KFHP External Provider Contract Template (KFHP Template_CO_Standard.pdf).** See highlighted text on page 5. • **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07 (Access to Care Policy.2017.pdf).** See Attachment A for all Accessibility of Services time standards. • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See pg 7, Appointment Scheduling Guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor communicates all scheduling guidelines in writing to participating providers. Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	• **Provider Manual – Quality Assurance and Improvement** (2016_Provider_Manual_Sec8_Quality.pdf). See pg 22, Accessibility Standards. Describes the standards, goals and methods of measurement for appointment scheduling guidelines. • **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07** (Access to Care Policy.2017.pdf). See Attachment A for all Accessibility of Services time standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-5—2.7.1.5.4	**Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07** (Access to Care Policy.2017.pdf). See Procedure to Implement Policy, paragraph 1, pg 2. This policy discusses timely access requirements, monitoring processes and results that may lead to a corrective action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes policies and procedures, training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-5—2.7.7.2	• **CATLAR Notice of language assistance** (CATLARTaglines_CM_CO_2016_Ltr.pdf). Demonstrates state specific non-English language assistance letter added to all essential member communications (e.g. Evidence of Coverage, Explanation of Benefits). • **CHP+ Evidence of Coverage – Plan 203** (CHP_DEN(07-16)-Plan203.pdf). See Contact Us for TTY, alternative formats and Spanish translation. See pg 1, Introduction (highlighted). • **Kp.org, Other Languages:** http://info.kaiserpermanente.org/html/gethelp/colorado.html • **Diversity Training Overview (diversity_l_and_d_program_overview_2016.pdf).** This document illustrates the diversity training requirements for Kaiser Permanente CO employees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	13

Total Score ÷ Total Applicable	=	93%

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Review Period:	January 1, 2016–December 31, 2016
Date of Review:	March 21, 2017
Reviewer:	Gina Stepuncik
Participating Plan Staff Member:	Thuyloan Giang

Requirements	File 1	File 2	File 3	File 4	File 5
Member	****	****	****	****	****
Date of initial request	12/23/16	08/31/16	11/07/16	12/18/16	01/11/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	CL	NR
Standard (S), Expedited (E), or Retrospective (R)	S	E	E	S	S
Date notice of action sent	12/29/16	09/01/16	11/07/16	01/06/16	01/21/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	6	1	0	19	10
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**5**	**5**	**5**	**5**	**5**
Total Compliant Elements	**5**	**5**	**5**	**5**	**5**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Requirements	File 6	File 7	File 8	File 9	File 10
Member	****	****	****	****	****
Date of initial request	09/26/16	12/29/16	07/14/16	04/04/16	09/22/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	E	S	S	S
Date notice of action sent	10/6/16	12/30/16	07/19/16	04/07/16	09/29/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	10	1	5	3	7
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	NA	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**6**	**5**	**6**	**6**
Total Compliant Elements	**6**	**6**	**5**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Total Record Review Score	**Total Applicable Elements: 54**	**Total Compliant Elements: 54**	**Total Score: 100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Kaiser**.

Table C-1—HSAG Reviewers and Kaiser and Department Participants

HSAG Review Team	Title
Gina Stepuncik	Project Manager
Kaiser Participants	**Title**
Carlos Madrid	Senior Manager, Medicaid; Clinical Operations, KP
Jeannie Hoover	Senior Manager, Compliance, KP
Luke Martin	Manager, Network Operations and Systems Administration, KP
Mark Learned, MD	Medical Director, Medicaid and CHP—KP/Colorado Permanente Medical Group (CPMG)
Megan Cheever	Senior Manager, Medicaid and Charitable Programs, KP
Paula Whittemore	Medicaid Referral Navigator, KP
Peggy Sparacino	Medicaid Regulatory Consultant, Medicaid and Charitable Coverage, KP
Robin Dam	Compliance Auditor, KP
Stephanie Gillan	Regulatory Coordinator, UM
Susan Pharo, MD	Medical Director, Medicaid and CHP (KP/CPMG)
Thuyloan Giang	Regulatory Manager, UM, KP
Department Observers	**Title**
Teresa Craig	CHP Program Manager, HCPF
Jerry Ware	Quality and Compliance Specialist, HCPF

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Appendix D. Corrective Action Plan Template for FY 2016–2017

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

Table D-1—Corrective Action Plan Process

Step	Action
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 site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for Kaiser

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is consistent with the symptoms, diagnosis, and treatment of a member's medical condition. – Is widely accepted by the practitioner's peer group as effective and reasonably safe based upon scientific evidence. – Is not experimental, investigational, unproven, unusual, or uncustomary. – Is not solely for cosmetic purposes. – Is not solely for the convenience of the member, subscriber, physician, or other provider. – Is the most appropriate level of care that can be safely provided to the member. – Failure to provide the covered service would adversely affect the member's health. – When applied to inpatient care, "medically necessary" further	While Kaiser clearly addressed the extent to which it is responsible for covering services within its *Authorizations of Services* policy, it has not specified within its policies and procedures the medical necessity criteria outlined in the State Medicaid Plan; nor did Kaiser refer to another source to obtain these criteria. In addition, Kaiser staff members should be aware that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, HSAG recommends that Kaiser update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.	Kaiser must update its UM policies and procedures to clearly define the medical necessity criteria outlined in the State Medicaid Plan as applicable to authorization decisions.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
means that covered services cannot be safely provided in an ambulatory setting. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments. – The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-5—1.1.1.58		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for CHP+ services.	Kaiser's *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. Staff members stated that Kaiser does not terminate or reduce previously approved authorizations for members. However, the policy omitted reference to other notification time frame requirements applicable to Medicaid members, specifically: • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, no later than the date the extension expires. • For denial of payment, at the time of any action affecting the claim.	Kaiser must update its policies and procedures to address all notification time frames applicable to members as outlined in the requirement.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
○ The member's address is determined unknown based on returned mail with no forwarding address. ○ The member is accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. ○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the timeframe, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211, 431.213,* and *431.214* 10CCR2505—10, Sec 8.209.4.A.3(a-c) Contract: Amendment 6, Exhibit A-5—2.8.1.3.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
4. The Contractor allows persons with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Contract: Amendment 6, Exhibit A-5— 2.7.5.4	During the on-site interview, Kaiser CHP+ staff members stated that practitioners make referrals to specialists within the KP provider network as needed to meet the needs of the member; however, for CHP+ members with special healthcare needs, Kaiser had no written procedures that address a process allowing direct access or standing referrals to specialists or allowing use of specialists as PCPs when indicated by members' health conditions.	Kaiser's policies and procedures must allow members with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or allow such members direct access or standing referrals to specialists.
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:		

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Appendix E. Compliance Monitoring Review Protocol Activities

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 Medicaid managed care regulations and 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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2016, and December 31, 2016 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. • 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 2016–2017 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 draft 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.