CHP+

Child Health Plan *Plus*

Fiscal Year 2018–2019 Site Review Report

for

Kaiser Permanente Colorado

February 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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 provisions of the Code of Federal Regulations (CFR), Title 42—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR 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 and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ health plans' compliance with new federal managed care regulations published May 2016, the Department determined that the review period for fiscal year (FY) 2018–2019 was July 1, 2018, through December 31, 2018. This report documents results of the FY 2018–2019 site review activities for **Kaiser Permanente Colorado** (**Kaiser**). For each of the four 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 describes the background and methodology used for the 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2018–2019 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.

Table 1-1 presents the scores for **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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	10	10	8	2	0	0	80%
IV. Member Rights and Protections	8	8	7	1	0	0	88%
VIII. Credentialing and Recredentialing	32	30	30	0	0	2	100%
X. Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
Totals	**68**	**66**	**61**	**5**	**0**	**2**	**92%**

*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 credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	100	96	96	0	4	100%
Recredentialing	90	87	87	0	3	100%
Totals	**190**	**183**	**183**	**0**	**7**	**100%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

Kaiser described all services provided through the **Kaiser** delivery system—an integrated care model—as the patient centered medical home (PCMH). All CHP+ members received most services through **Kaiser**'s employed and affiliate specialists and its hospital provider network. **Kaiser** demonstrated that it has system-wide resources dedicated to coordination of care for members, including numerous primary care clinic-based services supplemented by pediatric care coordination and complex case management programs for children with complex medical and developmental needs. To meet members' needs, these resources coordinate with multiple providers, agencies, and community organizations as indicated based on a needs assessment conducted by the primary care provider (PCP) or the care coordination team. **Kaiser** demonstrated active coordination of services for members: between multiple settings of care, including discharge planning from institutions; with services received from fee-for-service or other managed care plans; and with community and social support organizations. **Kaiser** used its HealthConnect electronic health record (EHR) system as the primary mechanism for documenting and communicating referrals, assessments, treatment or service plans, and progress notes related to care coordination. Members' consent to treatment plans is also documented in the electronic record. All network providers and staff members involved with a member's care have secured access to members' health information entered into the HealthConnect system. New Member Connect (NMC) outreaches to all new members to ensure they have an ongoing source of care and to conduct an initial needs assessment, which is communicated internally to providers through HealthConnect. Members are informed of how to contact their provider or any care coordinator involved with their case. Both the pediatric care coordination and complex case management programs are specifically designed to comprehensively assess, develop a service plan, and coordinate needed services for members with special health care needs (SHCN). All members may self-refer and directly access any internal **Kaiser** specialist. The PCP or care coordinators work with the utilization management (UM) team to obtain long-term approvals (usually six to 12 months) for members with SHCN when a referral to an external specialist is required.

Summary of Findings Resulting in Opportunities for Improvement

For this standard, all opportunities for improvement HSAG identified resulted in required actions, which are detailed below.

Summary of Required Actions

While **Kaiser** provided information indicating that it has various points of service through which the need for continuity of care for newly enrolled members may be identified or implemented, HSAG found that the various processes described include potential gaps in identifying a member to a provider that can ensure continuity of services when necessary, and that the processes do not clearly define the roles of practitioners or other **Kaiser** staff to ensure *provision* of necessary continuity of care services for newly

enrolled members. **Kaiser** must enhance procedures for providing continuity of care to newly enrolled members to ensure that any member identified to have continuity of care needs has timely follow-up—e.g., authorization processes for out-of-network providers or near-term contact with in-network providers—to prevent disruption in provision of services.

While **Kaiser** had mechanisms for conducting screening of each new member's needs, the assessment did not address all required categories of need. The Pediatric Care Coordination assessment did include all required assessment criteria but was not applicable to all new members. **Kaiser** must define and implement a process to conduct an initial assessment of each new member's needs (within 90 days of enrollment) which incorporates screening for all required assessment criteria—mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

Kaiser's policies and procedures and internal documents that addressed member rights and protections included all federally mandated CHP+ member rights, as well as articulated a spirit of respect toward members. The intent to respect member rights and ensure that rights are taken into account when furnishing services was also well-articulated in the CHP+ member handbook internal policies and procedures intended for staff and **Kaiser** medical group personnel use, and the provider manual intended for contracted providers. **Kaiser** provided evidence of initial and annual training regarding member rights for its staff members and providers.

Kaiser had adequate processes for ensuring that written communication is provided in languages and formats that meet the requirements of 42 CFR §438.10. **Kaiser** also had robust policies, procedures and organizational practices to ensure that members' privacy and confidentiality rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are protected. In addition, policies and procedures adequately addressed federal regulations related to advance directives, and information regarding advance directives was available on **Kaiser**'s website.

Summary of Findings Resulting in Opportunities for Improvement

For this standard, all opportunities for improvement HSAG identified resulted in required actions, which are detailed below.

Summary of Required Actions

In the description of member rights in member and provider materials, the member's right to "receive information in accordance with information requirements (42 CFR §438.10)" was presented as the *type* of information that the member has the right to receive, whereas 42 CFR §438.10 articulates

requirements about *how* the information must be presented by the health plan—i.e., that information be presented to the member in a language and format that would be best understood by the member (examples include easy-to-understand wording, alternative languages when applicable, and large print or other alternative formats when applicable). **Kaiser** must clarify the statement of member rights in member and provider materials to state that members have the right to receive information from the health plan in plain language, in English or an alternative language if preferred by the member, and in a way that takes the member's communication impairments into consideration.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

Kaiser demonstrated that it had a well-defined credentialing and recredentialing program that met all National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing practitioners and assessing organizational providers with which the health plan contracts for furnishing services to CHP+ members. **Kaiser**'s credentialing and recredentialing policies and procedures addressed all NCQA requirements for the selection and retention of practitioners providing care to Colorado's CHP+ members. Through on-site record reviews, HSAG confirmed that primary source verification occurred within the required time limits and that recredentialing occurred within 36 months following the initial credentialing or previous recredentialing date. On-site record review of a sample of contracted organizational providers demonstrated that **Kaiser** implemented procedures for ensuring that organizational providers remained in good standing with federal and State regulatory agencies, had not been excluded from federal healthcare participation, and employed processes for credentialing and recredentialing their own practitioners. **Kaiser** provided evidence of ongoing monitoring to ensure practitioners and providers had unrestricted licenses and had not been excluded from federal healthcare participation.

Kaiser directly credentialed and recredentialed all independently contracted practitioners and contracted organizational providers that served **Kaiser**'s CHP+ members. The **Kaiser** medical group's employed provider network was **Kaiser**'s primary source of practitioners to serve its CHP+ members. **Kaiser** had a delegation agreement with this medical group for credentialing and recredentialing practitioners and organizational providers that served CHP+ members through **Kaiser**'s clinics and facilities, as well as through the contracted providers' facilities. **Kaiser** provided evidence of adequate oversight to ensure the quality and completeness of the medical group's credentialing and recredentialing activities. In addition, **Kaiser** provided evidence of oversight for its additional credentialing and recredentialing delegate, University Physicians, Incorporated (UPI).

Summary of Findings Resulting in Opportunities for Improvement

Related to the NCQA requirement that health plans have and implement policies and procedures for ensuring that listings in provider directories and other member materials are consistent with credentialing data, **Kaiser**'s processes were adequate. The policy/procedures, however, stated only that

Kaiser updates the provider directory on an ongoing basis. HSAG recommended that **Kaiser** add additional description of the processes it uses to make these updates.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

Kaiser's Integrated Patient Care Quality Description and the *Executive Summary of CHP+ Activities* (report to the Service, Quality and Resource Management Committee [SQRMC]) described a multilevel, extensive process for oversight and analysis of quality related to CHP+ members. The Medicaid and Charitable Coverage Programs division—referred to as the MRC—managed the administration of the QAPI program specific to CHP+ members, which largely focused on the CHP+ performance improvement projects (PIPs), CHP+ Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] measures, quality of care concerns (QOCCs), and grievances and appeals. CHP+ members were also included in the system-wide **Kaiser** QAPI program which administers QAPI measures and initiatives applicable to the entire **Kaiser** population. The **Kaiser** regional SQRMC oversees the integrated patient care quality program. The MRC division was a participant of and annually reported its QAPI data to the SQRMC. **Kaiser** reported its CHP+ PIPs and HEDIS and CAHPS measures to the Department, as required. **Kaiser**'s PIP met the required design parameters, as previously evaluated by HSAG. Grievance and appeal data and quality of care concerns were trended quarterly. The SQRMC evaluated the structure and effectiveness of the integrated patient care quality program annually.

Kaiser's Clinical Knowledge Coordination Network/Guideline Committee (CKCN/GLC) was responsible for the development and approval of clinical practice guidelines in compliance with requirements. **Kaiser** had adopted practice guidelines for the specific health conditions required by its contract with the Department. Guidelines were posted on the clinical library website to be accessed by clinicians and staff throughout the organization. **Kaiser** also would notify providers and staff members through email, newsletters, or continuing medical education presentations, and, as applicable, would embed guidelines into the automated "smart-sets" in the EHR. Members could access clinical care guidelines during treatment visits to a clinic through the login to their personal medical file located on the **Kaiser** website or on the general **Kaiser** website (kp.org). Although **Kaiser** had several sources for development and approval of various guidelines, staff members stated that "ownership" of a guideline

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

implied the responsibility for proper implementation, which included ensuring that UM decisions, member education, and coverage were consistent with the guideline.

The Integrated Patient Care Quality Program Description described multiple data systems that collect data from various clinical and business points of contact throughout the **Kaiser** system, information exchange with external providers and organizations, and compilation of data in the system-wide data warehouse. Data included member and provider demographics, provider and hospital-based care, claims and referrals, appointments and visits, laboratory, radiology, and pharmacy. **Kaiser** demonstrated using its comprehensive systems to develop dashboards, reports, analysis, and ad hoc queries.

Kaiser's health information system (HIS) integrated claims data (collected in standardized electronic formats) with member eligibility files from the State and with provider tables maintained in the Tapestry system component for adjudication of the claim. All claims data are then transferred to the data warehouse. **Kaiser** provided documentation to confirm that it applies automated claims edits in Tapestry as well as manual claims edits to verify completeness, accuracy, coding appropriateness, logic, and consistency of claims data prior to adjudicating claims. The CHP+ Encounter Submission policy documented that **Kaiser** provides to the Department monthly batch submissions of encounter data reflecting paid, adjusted, or denied claims. **Kaiser** submits encounter claims data in the ASC X12N 837 and National Council for Prescription Drug Programs (NCPDP) file formats to the Department's fiscal agent.

Summary of Findings Resulting in Opportunities for Improvement

While on-site discussions verified that **Kaiser** has a process for ensuring decisions made in all areas to which clinical guidelines apply are consistent with the guidelines, HSAG recommends that **Kaiser** more formally outline in policies and procedures the accountability for doing so.

While PIPs and CHP+ HEDIS, CAHPS, and QOCC measures were reported, HSAG noted that the accompanying analysis lacked substantive interpretations of outcomes or related opportunities for improvement or interventions. For example, comments on QOCCs described sending concerns through a peer review process but did not include any indication of whether reported QOCCs might indicate an area of concern in the system of care. In addition, CHP+ HEDIS results indicated that six measures denoted low performance, with some showing substantial rate declines, which might suggest that members have barriers to accessing services for appropriate care; however, proposed interventions stated only that these measures would continue to be monitored. HSAG suggests that more in-depth analysis or follow-up interventions might contribute more meaningful substance to improving the quality of care for CHP+ members.

Summary of Required Actions

During on-site interviews, staff members described tracking of multiple utilization indicators throughout the delivery system; however, **Kaiser** did not produce evidence that the described utilization tracking processes resulted in an assessment or determination of over- or underutilization of specific services as a

component of the QAPI program. **Kaiser** must provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the QAPI program and analyzed as such.

Kaiser demonstrated that it has operational programs and resources to improve the quality of services rendered to individual members with SHCN; however, **Kaiser** did not provide evidence that the QAPI program included periodic evaluation of the overall quality of care being delivered to SHCN members or to a designated subset of these members. **Kaiser** must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 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 applicable federal managed care regulations and related managed care contract requirements was evaluated through review of all 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 federal Medicaid/CHP+ managed care regulations published 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+ credentialing and recredentialing.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements effective July 2018. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all CHP+ credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. 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.[2-3] 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 2018–2019 site reviews represent a portion of the managed care requirements. The following 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.

[2-3] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2018.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 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 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Related to member information, **Kaiser** had no required actions.

Related to provider participation and program integrity, **Kaiser** was required to:

- Develop a written provider retention policy.
- Develop a method to regularly assess whether billed member services have been received by members.

Related to the grievance system, **Kaiser** was required to:

- Ensure that it sends each member written acknowledgement of the grievance within two working days of receipt.
- Ensure that every member who files a grievance receives a written resolution notice.
- Ensure the grievance resolution notice includes the required content.
- Modify the appeal resolution template letter to ensure ease of understanding for the member.
- Include in the notice of appeal resolution that the member may be held liable for the cost of requested continued benefits.
- Include in policy and in the member handbook that the representative of a deceased member's estate is a party to a State fair hearing.

- Remove "authorized service time period or service limits have been met" as a qualification for how long member-requested benefits will continue during an appeal or State fair hearing.

HSAG scored all requirements for subcontracts and delegation as not applicable for CHP+ health plans due to an effective date, for new federal regulations, of July 1, 2018. As such, HSAG identified no required actions for this standard.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in April 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **Kaiser**. **Kaiser** submitted documents as evidence of completion of its proposed interventions in October 2018. **Kaiser** completed five of seven required actions for the grievance system; two required actions remained outstanding. **Kaiser** completed one of two required actions for provider participation and program integrity; one required action remained outstanding. HSAG returned the CAP review results to **Kaiser**, with a Department-determined due date for **Kaiser** to resubmit documents as evidence of completion of outstanding required actions.

Summary of Continued Required Actions

As of the date of this 2018–2019 compliance report, three 2017–2018 required actions were continued pending review of additional CAP documents to be submitted by **Kaiser**. HSAG will review **Kaiser**'s CAP submission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	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. **III. #21. Integration of Care in KPCOs Patient Centered Medical Home (PCMH),** page 2 (for bullets 1, 2, 3 and 5) **III. #22. Screenshot of Treatment Planning and Family Consent** (for bullet 3) **III. #5. Policy 3.1.1 Care Coordination Pediatric 2018, page 2, section 4.3** (for bullet 3) **III. #1. Complex Case Management Program Description** (for bullet 1) **III. #4. CHP+ EOC,** Section VII, B (for bullet 4) **III. #7. Authorization of Services17** (for bullet 4)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

Kaiser submitted documents and described during on-site interviews processes related to clinic-based PCMH care coordination, pediatric care coordination, and complex case management, which demonstrated coordinating member care with other providers, facilities, agencies, and community organizations; involving members and family members in consent to treatment plans; and having criteria and mechanisms for making referrals to specialists and other organizations. However, processes for providing continuity of care for newly enrolled members lacked clarity. New Member Connect (NMC) outreached all newly enrolled members to gather screening information that might indicate the need for continuity of care. Once the information was obtained, answers to screening questions were entered into the electronic health record (EHR) and sent to the member's primary care provider location; however, instructions to NMC staff indicated this transfer of information was not to be made to affiliate network providers; furthermore, the process did not account for members who may not yet be connected to a Kaiser PCP. HSAG also noted that, once new enrollee needs are identified, expectations or procedures to ensure that continuity of care is actually *provided*

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
are unclear. While the Authorization of Services policy addressed procedures for reviewing requests for continuity of care, it specified that "a covered person must have been undergoing treatment … by a provider being removed or leaving the network…," thereby making this process nonapplicable to newly enrolled members. HSAG found that the various processes described for ensuring continuity of care include potential gaps in identifying a member to a provider that can ensure continuity of services when necessary, and that these processes do not clearly define the role of practitioners or other Kaiser staff—e.g., UM staff—to ensure *provision* of necessary continuity of care services for newly enrolled members.		
Required Actions: Kaiser must enhance procedures for providing continuity of care to newly enrolled members to ensure that any member identified to have continuity of care needs has timely follow-up—e.g., near-term contact with in-network providers or authorization processes for out-of-network providers—to prevent disruption in provision of needed services.		
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	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. **III. #6. 2017_10_30 NewmemberIDCardInsert_DB_ FINAL.pdf** **III. #3. CHP+ New Member Guide 9.2017.pdf**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid.	The policies that are included which describe the ways that KP ensures coordination of care are below. **III. #5. Policy 3.1.1 Care Coordination Pediatric 2018,** page 2, Section 4.3 **III. #21. Integration of Care in KPCOs Patient Centered Medical Home (PCMH),** page 2 **III. #9. 2018 KPCO Integrated Patient Care Quality Program Description,** Section 2 page 33-35, Section 6 page 55-56 and pages 134-135	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract—Exhibit B—10.5.3.3.1		
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	Assessment of care coordination need based on physical, psychological, and social factors including special health care needs for mental health, functional problems, language barriers, and complex health problems that need follow up within 90 days is addressed in the following policy: **III. #5. Policy 3.1.1 Care Coordination Pediatric 2018,** Section 4.3 **III. #10. JA – Call Routing to MOB.pdf** **III. #11. SOP Pediatric.pdf**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The NMC department attempted outreach to each new member when he or she enrolled to conduct a screening of the member's needs based on questions regarding medications, specialists being seen, previous hospitalizations, or underlying medical conditions. The screening did not include assessment of functional problems or language/comprehension barriers. The Pediatric Care Coordination policy described assessment of each of the factors described in the requirement; however, this process applied only to members referred to complex case management.		
Required Actions: Kaiser must define and implement a process to conduct an initial assessment of each new member's needs (within 90 days of enrollment) which incorporates screening for all required assessment criteria—mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.6.1	Information is shared with other entities through our EMR and Affiliate link systems to alert of member's needs and prevent duplication of services. **III. #9. 2018 KPCO Integrated Patient Care Quality Program Description,** Section 2 page 28-31, 132 **III. #14. 2018_KPCO_Provider_Manual_Section_6_ Provider _Rights,** page 9 & 13	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—14.1.6.6–7	These documents describe KP's processes to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record. **III. #9. 2018 KPCO Integrated Patient Care Quality Program Description,** page 132 **III. #14. 2018_KPCO_Provider_Manual_Section_6_ Provider _Rights,** page 9 & 13 **III. #15. 2018_KPCO_Provider_Manual_Section_8_ Quality_Assurance_and_Improvement,** page 19	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. 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 (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.1.1	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. **III. #16. Principals of Responsibility,** Section 2. & 2.1 pages 12-15 **III. #17. 2018_KPCO_Provider_Manual_Section_9_ Compliance,** page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor implements mechanisms to comprehensively assess each Medicaid member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.6.2	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. **III. #4. CHP+ EOC** **III. #7. Authorization of Services Policy & Procedures** **III. #5. Policy 3.1.1 Care Coordination Pediatric 2018**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the enrollee. • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.3.2.1–4	Treatment Plans for members with special health care needs who are described in the following documents. **III. #21. Integration of Care in KPCOs Patient Centered Medical Home (PCMH),** page 2 **III. #22 Screenshot of Treatment Planning and Family Consent** **III. #9. 2018 KPCO Integrated Patient Care Quality Program Description,** Section 2 page 33-34	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.3.5; 10.6.3	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. **III. #4. CHP+ EOC**, page 4, section B. Getting a Referral and page 8, Section G. Continuity of Care Provision **III. #7. Authorization of Services,** page 1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	8
Total Score ÷ Total Applicable						=	80%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—14.1.1.2	The Member Rights Policy and the CHP+ EOC specify the rights provided to CHP+ members. **IV. #1 CHP+ KP Member Rights Policy,** Paragraph #1, #2 and #4 **IV. #2 CHP+ EOC,** Section XIII Member Rights & Responsibilities, page 39, Section XII, Advance Directives, page 36	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract: Exhibit B—14.1.1.1	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. **IV. #3 2018 Provider Manual**, Section 7.1 page 4 and CHP+ Members paragraph page 6 **IV. #4 Principles of Responsibility**, Section 1.2 Refer to and Follow Laws, Regulations, and Policies **IV. #2 CHP+ EOC,** Section XIII Member Rights & Responsibilities, page 39	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy.	The Member Rights Policy & CHP+ EOC specify the guaranteed rights provided to CHP+ members. **IV. #1 CHP+ KP Member Rights Policy,** Paragraph #4 **IV. #2 CHP+ EOC,** Section XIII Member Rights & Responsibilities, page 39	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3		
Findings: The member's right to "receive information in accordance with information requirements (42 CFR §438.10)" was presented in Kaiser's member and provider materials as the *type* of information that the member has the right to receive, whereas 42 CFR §438.10 articulates requirements about *how* the information must be presented by the health plan. That is, 42 CFR §438.10 requires that information be presented to the member in a language and format that would be best understood by the member (examples include easy-to-understand wording, alternative languages when applicable, and large print or other alternative formats when applicable).		
Required Actions: Kaiser must clarify the description of member rights in member and provider materials to state that members have the right to receive information from the health plan in plain language, in English or an alternative language if preferred by the member, and in a way that takes the member's communication impairments into consideration.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the State Medicaid agency treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—14.1.1.2.6	The Member Rights Policy & CHP+ EOC specifies that the member is free to exercise his/her rights without adverse effects. **IV. #1 CHP+ KP Member Rights Policy,** Paragraph #4 **IV. #2 CHP+ EOC,** Section XIII Member Rights & Responsibilities, page 39 **IV. #3 2018 Provider Manual**, Section 7.1 CHP+ Members paragraph page 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. Member's rights and responsibilities are included in the member handbook and provided to all enrolled members. *42 CFR 438.10(2)(ix)* Contract: Exhibit B—14.1.3.10	Member rights and responsibilities are included in KP CHP+ New Member Guide, CHP+ EOC. **IV. #5 CHP+ New Member Guide 9.2017.pdf, page 5** **IV. #2 CHP+ EOC,** Section XIII Member Rights & Responsibilities, page 39	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor complies with any other federal and State laws that pertain to member rights, including Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.A	The Nondiscrimination in the Provision of Healthcare policy complies with federal and state laws. **IV. #7 Nondiscrimination in the Provision of Healthcare,** Page 1 Section 1 & 2, page 6 Colorado Addendum	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. For medical records and any other health and enrollment information which identify a particular member, 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. *42 CFR 438.224* Contract: Exhibit B—14.1.6.7	The Provider Manual, expresses the member's right to be assured of privacy and confidentiality. **IV. #3 2018 Provider Manual,** Section 7, page 5 **IV. #2 CHP+ EOC,** Section I. Privacy Practices page 37 **IV. #12 Privacy and Information Security Policies, Procedures and Documentation**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include: • A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive.	Life Care Planning is addressed in multiple documents listed below. **IV. #2 CHP+ EOC,** Section XII, Advance Directives, page 36 **IV. #8 Life Care Planning, My values, my choices, my care** **IV. #9 Life Care Planning First Steps – Documenting the Health Care Agent** **IV. #10 LCP_Info Bklet.pdf** **IV. #11 Life Care Planning overview** **IV. #13 EOL Policy 6.25.2018,** page 4, section 5.1.1 **IV. #14 Life Care Planning Job Aide** **IV. #15 Example KP_Healthcare Planning Class for public** **IV. #16 Life Care Planning Class** **IV. #17 Life Care Planning Class Search**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives. • Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	7
Total Score ÷ Total Applicable						=	88%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor's credentialing program complies with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of participating providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.3	This document identifies our process for ensuring the evaluation and selection of providers that meet standards established by KP and all applicable regulatory and accreditation agencies, including NCQA. See identified section. **VIII #1. Policy 5434-01 - Purpose of Credentialing: Authority for Credentialing Policies & Procedures,** Section I. Authority for Credentialing, B. **VIII #21 NCQA Certificate Letter.pdf**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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: • The types of practitioners it credentials and recredentials. This includes all physicians and non-physician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavioral health provider.) NCQA CR1—Element A1	This document identifies our policy and authority regarding credentialing and recredentialing; and lists the providers and heath care professionals covered by the policy. See identified section. **VIII #1. Policy 5434-01 - Purpose of Credentialing: Authority for Credentialing Policies & Procedures**, Section I. Authority for Credentialing, A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's written policies and procedures for the selection and retention of providers specify: • The verification sources it uses. NCQA CR1—Element A2	These documents identify the verification sources used during the initial credentialing and recredentialing processes. See identified section. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. - B. Credentialing Verification Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII #4. Practitioner Recredentialing Policies and Procedures, Section I. - B. Credentialing Verification Process	
4. The Contractor's written policies and procedures for the selection and retention of providers specify: • The criteria for credentialing and recredentialing. NCQA CR1—Element A3	These documents identify the criteria used during the initial credentialing and recredentialing processes. See identified section. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – A&B **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – A&B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	These documents describe the elements considered in the decision-making process during the initial credentialing and recredentialing processes. See identified section. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – C. Credentialing Review **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – C. Recredentialing Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for managing credentialing and recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	These documents describe the process for the files that meet established criteria for initial credentialing and recredentialing. See identified section. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – C. Credentialing Review **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – C. Recredentialing Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	This document describes delegation of credentialing and recredentialing. **VIII #5. Policy 5434-05: Affiliated Practitioner Credentialing: Delegated/Non-Delegated/Facility-Based Policies & Procedures**, Section II. A. Delegated Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic or national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes). NCQA CR1—Element A7	This document gives the current nondiscrimination policy statement for both credentialing and recredentialing. **VIII #1. Policy 5434-01 - Purpose of Credentialing: Authority for Credentialing Policies & Procedures,** Section II. G. Credentialing Committee Non-Discrimination Review 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	evidence of discrimination. The report is then reviewed by the Credentialing Committee. This report is prepared in Q1 of each year and reviews providers undergoing credential or recredentialing from the previous calendar year (reporting on activity in calendar year 2016). **Annual Non-discrimination Report 2017**	
9. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information 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. **VIII #2. Policy 5434-02 – Access & Confidentiality of Information Policy & Procedures** – Section II Right to Review Credentialing Information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	These documents describe the policy for notifying the provider of the credentialing committee's decision for the initial credentialing and recredentialing processes. See indicated section. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – D. Practitioner Notification **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – D. Practitioner Notification	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's written policies and procedures for the selection and retention of providers specify: • The medical director's 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. **VIII #1. Policy 5434-01 - Purpose of Credentialing: Authority for Credentialing Policies & Procedures** Section II. B. Role of Committee Co-Chairs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process. NCQA CR1—Element A11	This policy describes the agreement to maintain confidentiality of information obtained in the credentialing/recredentialing process. **VIII #2. Policy 5443-02: Access & Confidentiality of Information Policies & Procedures**, Section III. Confidentiality	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's written policies and procedures for the selection and retention of providers specify: • 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	This policy outlines the process for ensuring that the CHP+ provider directory is consistent with credentialing data, and inclusive of education, training, certification, and specialty. **9. Policy 6103-20: Practitioner and Provider Directory Policy & Procedure,** page 1, page 3 section 5.1 and page 5 section 5.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contactor notifies practitioners about their rights: • To review information submitted to support their credentialing or recredentialing application. • To correct erroneous information. • To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B	This document contains a notification to providers of their right to review information. See identified section. **VIII #10. 6 CCR 1014-4 Colorado Health Care Professional Credentials Application** (initial/recred) page 23 #12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee uses participating practitioners to provide advice and expertise for credentialing decisions. NCQA CR2—Element A1	This document describes the credentialing committee and their responsibilities. **VIII #1. Policy 5434-01 - Purpose of Credentialing: Authority for Credentialing Policies & Procedures** Section II. A-F	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. 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—Element A2 and A3	These sections describe the process and committee responsibilities for reviewing practitioners not meeting thresholds during the initial credentialing recredentialing process. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – C. Credentialing Review **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – C. Credentialing Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor verifies credentialing and recredentialing information through primary sources to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: • A current, valid license to practice (verification time limit=180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit=prior to the credentialing decision).	These documents detail the verification process for credentialing and recredentialing within prescribed time limits. See identified sections. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. – A. & B. **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. – A. & B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Education and training—highest level obtained—e.g., medical/ professional school graduate; residency (verification time limit=prior to the credentialing decision). Required at initial credentialing only. • Board certification—if the practitioner states on the application that he or she is board certified (board certification time limit=180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or curriculum vitae (CV) (verification time limit=365 calendar days). Required at initial credentialing only. • History of malpractice settlements—most recent five years (verification time limit=180 calendar days). NCQA CR3—Element A		
18. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit=180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	These documents describe verification of sanction activities for credentialing and recredentialing. See identified sections. **VIII #3. Policy 5434-03: Initial Practitioner Credentialing Policies and Procedures**, Section I. –B. 1 & 4 **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Section I. –B. 1 & 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following: • Reasons for inability to perform the essential functions of the position. • 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 or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil). • Attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	This is the application completed by practitioners for both initial credentialing and recredentialing. **VIII #10. 6 CCR 1014-4 Colorado Health Care Professional Credentials Application** • Supplemental B #1-3 • Supplemental A #3 • XII – Attestation Questions p. 19-20 • XII – Attestation Questions p. 19-20 • X. Professional Liability Insurance p. 16-17 • XIII. Attestation & Signature p. 21	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor formally recredentials practitioners at least every 36 months. NCQA CR4	This document specifies the timing of recredentialing. See identified section. **VIII #4. Policy 5434-04: Practitioner Recredentialing Policies and Procedures**, Procedure I.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor has and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies issues related to poor quality. Monitoring includes: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure.	These policy and procedure documents describe collecting and reviewing all sanctions, limitations, complaints or adverse events impacting a provider's ability to practice, and the actions taken when any of the above are identified. **VIII #6. Policy 5434-06: Ongoing Monitoring of Sanctions and Complaints Policies & Procedures – Procedures**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**VIII #11. Policy CO.RCO.012: Identifying and Responding to Ineligible Individuals and Entities,** 5.1.1, 5.2, 5.3, 5.4 **VIII 12. Policy 7202-06: Regional Semi-Annual Complaints Review**, 1.0, 2.0, 3.2	
22. The Contractor has policies and procedures for taking action against a practitioner for quality reasons, reporting the action to the appropriate authorities, and offering the practitioner a formal appeal process. Policies and procedures address: • The range of actions available to the Contractor to improve practitioner performance before termination. • Procedures for reporting to National Practitioner Data Bank (NPDB), State agency, or other regulatory body, as appropriate. NCQA CR6—Element A1 and A2	This policy and procedure document describes the range of actions taken and reporting practices for addressing quality. **VIII 13. Policy 7202-17: Practitioner Performance Review and Oversight**, 8.0, 8.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. When taking action against a practitioner for quality reasons, the Contractor offers the practitioner a formal appeal process. Policies and procedures address: • A well-defined practitioner appeal process, including: – Written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process. – Allowing practitioners to request a hearing and the specific time period for submitting the request.	This document describes the practitioner's appeal process for actions taken against the practitioner. **VIII 14. CPMG and Affiliated Practitioners Fair Hearing Policy & Procedures** – Sections 4.5 & 5.0-8.5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Allowing at least 30 calendar days, after notification for practitioners, to request a hearing. – Allowing practitioners to be represented by an attorney or another person of their choice. – Appointing a hearing officer or a panel of individuals to review the appeal. – Notifying practitioners of the appeal decision in writing, including specific reasons for the decision. • Making the appeal process known to practitioners. NCQA CR6—Element A3 and A4		
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the provider is in good standing with State and federal regulatory bodies. – Policies specify the sources used to confirm—which may only include applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., state licensure) from the provider. NCQA CR7—Element A1	This document contains the initial and ongoing assessment policy for organizational providers. **VIII #3. Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service**, 6.2, 7.1, 7.2, Attachment 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor confirms, initially and at least every three years, provider review and approval by an accrediting body. • Policies specify the sources used to confirm—which may only include applicable State or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials—e.g., licensure, accreditation report or letter—from the provider. NCQA CR7—Element A2	This document contains the initial and ongoing assessment policy for organizational providers. **VIII #3. Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service**, 6.3, 7.3, 7.4, 7.7, Attachment 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that that the provider credentials its practitioners. • 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 CR7—Element A3	This document contains the initial and ongoing assessment policy for organizational providers. **VIII #3. Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service**, 6.4, Attachment A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor's organizational provider assessment policies and processes include assessment of at least the following medical providers: • Hospitals • Home health agencies • Skilled nursing facilities • Freestanding surgical centers NCQA CR7—Element B	This document contains the initial and ongoing assessment policy for organizational providers which is inclusive of the medical providers listed. **VIII #15. Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service**, 3.0, Attachment 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR7—Element D	This document contains documentation of assessment of contracted providers. **VIII #16. Organizational Credentialing Spreadsheet**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. If the Contractor delegates any NCQA-required credentialing or recredentialing activities, 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. • Specifies that the organization retains the right to approve, suspend, or terminate individual practitioners, providers, and sites—even if the organization delegates decision making.	This document contains the 2015 delegation agreement with specified organizational provider which describes the required activities. **VIII #17. University Physicians, Inc – 2015-9-24 Agreement for Delegated Credentialing Services, page 1, page 3 - Section III and page 13 – Exhibit A: Delegated Activities Grid**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill obligations. NCQA CR8—Element A		
30. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: • The allowed uses 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 use of information occurs. • A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR8—Element B	**Not Applicable, delegated agreement does not include use of PHI**	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Kaiser reported that delegates use only aggregated or de-identified quality of care information to for making recredentialing decisions.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. For new delegation agreements in effect fewer than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. NCQA CR8—Element C	**Not Applicable, delegated agreement in effect for over 12 months**	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Both of the health plan's credentialing delegation agreements have been in effect more than 12 months.		
32. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegates' credentialing policies and procedures. • Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. • Annually evaluates delegate performance against NCQA standards for delegated activities. • Semiannually evaluates delegate reports specified in the written delegation agreement. • At least once in each of the past two years, identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Elements D and E	This document contains the results of the most recent audit of credentialing files. **VIII #18. 2018 UPI- Audit Summary,** page 1 **VIII #19. 2018 UPI- Audit Approval Letter Signed** **VIII #20. University Physicians Inc. Semi Annual Delegation reports 2017-2018**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* Contract: Exhibit B—12.1	Quality assessment and improvement tis the key function of the KPCO Integrated Patient Care Quality Program. The document below describes the program. **X. #1 2018-KP_CHP+QAPI_Final for HCPF.pdf**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B—12.3.1, 12 3.2, 12.3.4	The QAPI is provided below and documentation from the HCPF that it was received. **X. #1 2018-KP_CHP+QAPI_Final for HCPF.pdf** **X. #2 Email Receipt KP Annual QAPI**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B—12.4.1, 12.4.2	The QAPI provides performance measures using standards identified by the state. **X. #1 2018-KP_CHP+QAPI_Final for HCPF.pdf,** page 10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	Utilization management is reviewed as part of the IPCQ and SQRMC Programs. **X. #1 2018-KP_CHP+QAPI_Final for HCPF.pdf,** page 10 **X. #3 Charitable Program Quality Report – HEDIS** **X. #4 2018 KPCO Integrated Patient Care Quality Program Description,** Section 10 page 66-68	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Integrated Patient Care Quality Program Description stated that utilization is tracked using data from HealthConnect and claims. Both cost and utilization of services—such as office visits, outpatient and inpatient laboratory, radiology, and pharmacy—are tracked by Department and venue. During on-site interviews, KPMG staff members described monitoring costs of care across clinic sites by diagnosis, vaccine rates, and other HEDIS indicators and readmission data, and that this information was considered in the annual review of program effectiveness report to the SQRMC. Nevertheless, Kaiser did not produce evidence that the described utilization tracking processes resulted in an assessment or determination of over- or underutilization of specific services as a component of the QAPI program.		
Required Actions: Kaiser must provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the QAPI program and analyzed as such.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI program includes investigation of any alleged quality of care concerns. Contract: Exhibit B—12.4.5.1	Quality of Care Concerns are addressed through our Customer Experience Grievance process for CHP+ Members. **X. #4 2018 KPCO Integrated Patient Care policy,** Section 4. Page 40-43 **X. #5 CHP+ Medicaid Grievance Process 2018.pdf** **X. #6 Complaints Referred to the Quality Department from Regional Nurse Screeners – Colorado Region**, 1.0 Policy Statement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	The documents below include our quality and appropriateness of care furnished to members with special health care needs. **X. #4 2018 KPCO Integrated Patient Care policy,** page 58 **X. #7 Complex Case Management Program Description,** page 1 -2 **X. #8 Policy 3.1.1 Care Coordination 2018**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser demonstrated that it has operational programs and resources to improve the quality of services rendered to individual members with SHCN—e.g., care coordination services for members with complex health needs; however, Kaiser did not provide evidence that the QAPI program included periodic evaluation of the overall quality of care being delivered to SHCN members or to a designated subset of these members.		
Required Actions: Kaiser must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	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. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 37 & Annual Review on page 40	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated at least every two years. *42 CFR 438.236(b)* Contract: Exhibit B—12.2.1.2	In addition to the clinical guidelines described, these documents specifically outline how guidelines are developed as well as how physicians may access continuing medical education. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 23	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care.	Included below are several example clinical guidelines which meet this standard, as well as documentation regarding the documentation of member conditions in Health Connect. **X. #9 Prenatal Care** **X. #10 Prenatal Care – Second & Third Trimester** **X. #11 Postpartum Care**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—12.2.1.1	**X. #12 Developmental Delay and Autism Pathways** **X. #13 Diagnosis and Treatment of ADHD in Children & Adolescents** **X. #14 Down's Syndrome** **X. #20 Peds Immunization Schedule**	
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, non-members, and the public—at no cost. *42 CFR 438.236(c)* Contract: Exhibit B—12.2.1.3	The following document describes how the guidelines are disseminated. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description,** page 130-132 **X. #15 2018 KPCO_Provider_Manual_Section_7_ Member Rights,** page 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B—12.2.1.4	The following document describes how utilization management guidelines are consistent with the guidelines. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description,** page 10 Section 2 through page 43 **X. #16 Clinical Guideline Policy and Procedure – 2018**, Section 4.1.1 and 4.1.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	QPA maintains a health information system that collects, analyzes, integrates and reports data. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 31–32, 132-135	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	KP uses the HealthTrac database to combine clinical information, membership demographics, and communications with members to integrate data for care management and reporting needs. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 29 – 30	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B—18.2.1	CHP+ Encounter Submission policy addresses how KP's claims processing and retrieval systems collect data and elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. **X. #21 Kaiser Permanente Colorado CHP+ Encounter Submission Policy.pdf,** section 5.0	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B—12.4.10.2	CHP+ Encounter Submission policy addresses how KP's claims processing and retrieval systems collect data and elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 30, Data Governance and Data Quality **X. #21 Kaiser Permanente Colorado CHP+ Encounter Submission Policy.pdf,** section 5.0	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for Medicaid quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B—12.4.10.3.1	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. **X. #4 2018 KPCO Integrated Patient Care Quality Program Description**, page 30, Data Governance and Data Quality	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837, NCPDP, and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B—18.2.6; 18.2.7, 18.2.8	CHP+ Encounter Submission policy addresses how KP's claims processing and retrieval systems collect data and elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. **X. #21 Kaiser Permanente Colorado CHP+ Encounter Submission Policy.pdf,** section 1.0, 2.0 & 5.0	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Enrollment and disenrollment information. Contract: Exhibit B—12.4.3.2	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. **X. #1 2018-KP_CHP+QAPI_Final for HCPF.pdf,** page 10 **X. #19 KP CHP+ Quarterly Report**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	89%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Kaiser Permanente Colorado

Review Period:	July 1–December 31, 2018
Date of Review:	December 6, 2018
Reviewer:	Barbara McConnell and Katherine Bartilotta
Health Plan Participant:	Beth Champlin, Chea Sanchez, and Audra Vasquez

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Credentialing Date	07/01/18	07/01/18	08/10/18	08/23/18	09/15/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**10**	**9**	**9**	**9**	**10**
Number of compliant elements	**10**	**9**	**9**	**9**	**10**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Credentialing Date	09/20/18	09/27/18	10/01/18	10/05/18	11/02/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**10**	**10**	**10**	**9**	**10**
Number of compliant elements	**10**	**10**	**10**	**9**	**10**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Total number of applicable elements	**96**
Total number of compliant elements	**96**
Overall percentage compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Recredentialing Record Review Tool
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Review Period:	July 1–December 31, 2018
Date of Review:	December 6, 2018
Reviewer:	Barbara McConnell and Katherine Bartilotta
Health Plan Participant:	Beth Champlin, Chea Sanchez, and Audra Vasquez

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	07/23/18	11/03/15	08/01/15	03/24/16	09/24/15
Current Recredentialing Date	07/20/18	08/17/18	08/23/18	09/27/18	09/27/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**9**	**8**	**9**	**8**
Number of compliant elements	**9**	**9**	**8**	**9**	**8**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

Comments:

Sample #	6	7	8	9	10
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	11/03/15	09/01/16	10/22/15	03/24/16	12/08/15
Current Recredentialing Date	10/05/18	10/25/18	10/25/18	10/25/18	11/02/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**9**	**9**	**8**	**9**
Number of compliant elements	**9**	**9**	**9**	**8**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

Total number of applicable elements	**87**
Total number of compliant elements	**87**
Overall percentage compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **Kaiser**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
Kaiser Participants	**Title**
Annika Brugman	Senior Regulation Consultant for Benefit and Policy
Audra Vasquez	Credentialing Coordinator
Beth Anderson	Compliance Auditor
Beth Champlin	Manager, Credentialing
Carlos Madrid	Senior Manager, Medicaid
Cathy Johnson	Managed Care Provider Operations
Chara Hoover	Senior Manager, Compliance
Chea Sanchez	Supervisor, Credentialing
Christine Jelinek	Regional Medical Director
Christy Dupree	Quality
DeAnna Thompson	Contract Administration
Derrick Washington	Operations Manager, Administration
Dianne Koepping	NCQA Accreditation
Hector DeLeon	Medical Director
Jama Back	Quality
Jeanne Hoover	Senior Manager, Health Plan Compliance
Jennifer Jones	Resource Stewardship
JoAnne Doherty	Senior Consultant
Jon Friesen	Director of Compliance
Kathy Westcoat	Senior Director, Medicaid
Keechia Traub	Quality
Kirsten Swart	Compliance
Liz Chapman	Managed Care Provider Operations
Mark Learned	Medical Director
Megan Cheever	Managed Care Provider Operations

Kaiser Participants	Title
Nancy Alms	Director, Contracting
Nancy Lubuye	Analyst
Nikki Fitt	Manager, Compliance
Robin Dam	Compliance Auditor
Sandy Williams	Provider Experience and Contracting
Shanee Courtney	Senior Manager
Tammy Kelly	Senior Innovations
Tia Stakely	Project Coordinator
Toni Meyer	Project Coordinator
Tonya Bruno (telephonic)	Manager, Managed Care Providers
Department Observers	**Title**
Russell Kennedy	Quality Improvement
Teresa Craig (telephonic)	Program Manager

Appendix D. Corrective Action Plan Template for FY 2018–2019

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 and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the health plan's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for Kaiser

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	Kaiser submitted documents and described during on-site interviews processes related to clinic-based PCMH care coordination, pediatric care coordination, and complex case management, which addressed most State requirements. However, processes for providing continuity of care for newly enrolled members lacked clarity. New Member Connect (NMC) outreached all newly enrolled members to gather screening information that might indicate the need for continuity of care. Once the information was obtained, answers to screening questions were entered into the electronic health record (EHR) and sent to the member's primary care provider location; however, instructions to NMC staff indicated this transfer of information was not to be made to affiliate network providers; furthermore, the process did not account for members who may not yet be connected to a Kaiser PCP. HSAG also noted that, once new enrollee needs are identified, expectations or procedures to ensure that continuity of care is actually *provided* are unclear. While the Authorization of Services policy addressed procedures for reviewing requests for continuity of care, it specified that "a covered person must have been undergoing treatment … by a provider being removed or leaving the network…," thereby making this process nonapplicable to newly enrolled	Kaiser must enhance procedures for providing continuity of care to newly enrolled members to ensure that any member identified to have continuity of care needs has timely follow-up—e.g., near-term contact with in-network providers or authorization processes for out-of-network providers—to prevent disruption in provision of needed services.

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
	members. HSAG found that the various processes described for ensuring continuity of care include potential gaps in identifying a member to a provider that can ensure continuity of services when necessary, and that these processes do not clearly define the role of practitioners or other Kaiser staff—e.g., UM staff—to ensure *provision* of necessary continuity of care services for newly enrolled 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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	The NMC department attempted outreach to each new member when he or she enrolled to conduct a screening of the member's needs based on questions regarding medications, specialists being seen, previous hospitalizations, or underlying medical conditions. The screening did not include assessment of functional problems or language/comprehension barriers. The Pediatric Care Coordination policy described assessment of each of the factors described in the requirement; however, this process applied only to members referred to complex case management.	Kaiser must define and implement a process to conduct an initial assessment of each new member's needs (within 90 days of enrollment) which incorporates screening for all required assessment criteria—mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.
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 guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).	The member's right to "receive information in accordance with information requirements (42 CFR §438.10)" was presented in Kaiser's member and provider materials as the *type* of information that the member has the right to receive, whereas 42 CFR §438.10 articulates requirements about *how* the information must be presented by the health plan. That is, 42 CFR §438.10 requires that information be presented to the member in a language and format that would be best understood by the member (examples include easy-to-understand wording, alternative languages when applicable, and large print or other alternative formats when applicable).	Kaiser must clarify the description of member rights in member and provider materials to state that members have the right to receive information from the health plan in plain language, in English or an alternative language if preferred by the member, and in a way that takes the member's communication impairments into consideration.

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
42 CFR 438.100(b)(2) and (3) Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3		
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	The Integrated Patient Care Quality Program Description and on-site interviews stated that utilization is tracked using a variety of data from HealthConnect and claims and that this information was considered in the annual review of program effectiveness report to the SQRMC. Nevertheless, Kaiser did not produce evidence that the described utilization tracking processes resulted in an assessment or determination of over- or underutilization of specific services as a component of the QAPI program.	Kaiser must provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the QAPI program and analyzed as such.
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**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g. medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	Kaiser demonstrated that it has operational programs and resources to improve the quality of services rendered to individual members with SHCN—e.g., care coordination services for members with complex health needs; however, Kaiser did not provide evidence that the QAPI program included periodic evaluation of the overall quality of care being delivered to SHCN members or to a designated subset of these members.	Kaiser must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with SHCN.
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

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 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 Integrated Quality Improvement Committee (IQuIC) 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 a list of all credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). 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 credentialing and recredentialing of providers. • While on-site, HSAG collected and reviewed additional documents as needed. • 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 2018–2019 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.