CHP+

Child Health Plan *Plus*

Fiscal Year 2019–2020 Site Review Report

for

Kaiser Permanente

March 2020

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

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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 federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was January 1, 2019, through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **Kaiser Permanente** (**Kaiser**). For each of the 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 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials) record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2019–2020 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.

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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)
I. Coverage and Authorization of Services	36	31	21	5	5	5	68%
II. Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**47**	**37**	**5**	**5**	**5**	**79%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **Kaiser** for the denial 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)
Denials	90	61	40	21	29	66%
Totals	**90**	**61**	**40**	**21**	**29**	**66%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

Kaiser demonstrated through policies and procedures and on-site interviews that it has implemented an effective operational infrastructure to support coverage and authorization of services. Although policies and procedures were applicable to all lines of business, **Kaiser** differentiated specific CHP+ requirements where applicable. Utilization management (UM) processes included application of CHP+ medical necessity criteria and Milliman guidelines to make authorization decisions, with UM physicians and a team of specialty physician consultants available for making final UM determinations. On-site record reviews demonstrated that UM decision-makers have appropriate clinical expertise in treating the member's condition. **Kaiser** conducted annual interrater reliability testing to ensure consistent application of guidelines. **Kaiser** notified members and providers in writing of any denial of authorization decisions within the required time frames and attached appeal rights and processes to each notice of adverse benefit determination (NABD). The Authorization of Services policy and on-site interviews confirmed that **Kaiser** never denies previously authorized services. **Kaiser** time-stamped receipt of authorization requests and mailing of notices to members, thereby enabling compliance with the 72-hour time fame for expedited decisions, when applicable.

Kaiser does not require prior authorization for emergency services, and staff members confirmed that **Kaiser** does not review and auto-pays all emergency service claims, whether services were delivered in or out of network. Staff members stated that poststabilization services—such as inpatient hospitalization—require authorization for medical necessity. **Kaiser** demonstrated a process for pending poststabilization claims without an authorization and forwarding the case to the UM staff for a medical necessity determination and a final claim adjudication decision.

Summary of Findings Resulting in Opportunities for Improvement

Although **Kaiser**'s operational processes for UM decision-making were largely compliant with requirements, communications to members regarding denials and appeal processes included numerous deficiencies resulting in the required actions below. In addition, the NABD included extensive—sometimes unnecessary—information regarding the reason for the denial as well as appeals information, resulting in an excessively lengthy and potentially confusing communication to the member. HSAG recommends that **Kaiser** simplify its NABD by eliminating information not pertinent to the denial or the member's "need to know."

Whereas **Kaiser** does not deny previously authorized services, and the member's right to have benefits continue applies only to denial of previously authorized services, HSAG recommends that **Kaiser** consider removing continuing benefit information from appeal information in the NABD. Similarly, information in the *CHP+ Evidence of Coverage* (EOC) communicates the time frame for notifying the member of termination or reduction of previously authorized services and includes extensive continuation of benefits information, which conflicts with **Kaiser**'s implemented UM processes. HSAG

recommends that **Kaiser** ensure that member communications are consistent with **Kaiser**'s actual procedures.

The NABD template language included numerous terms beyond the sixth-grade reading level, and HSAG found that all records included in the record review sample failed to meet the requirement, "correspondence with the member was easy to understand." HSAG recommends that **Kaiser** consider developing a specific CHP+ member template and implement a mechanism to review autogenerated NABD letter content for clarity prior to mailing the NABD to the member.

Information in the NABD informing the member of the letter's availability in other languages appears in the appeals attachment but not in the body of the letter. The NABD also does not inform the member of the availability of the letter in alternative formats for members with special needs (e.g., visually impaired). Whereas member communications requirements (reviewed in another standard) require all critical member materials to include these taglines, HSAG recommends that **Kaiser** update its NABD to include such information in the body of the NABD.

While **Kaiser**'s UM policies described that reviewers *may* outreach to the requesting provider to obtain additional information for an authorization, HSAG found that one of the records in the record review sample failed to document appropriate consultation with the requesting provider. Therefore, HSAG recommends that **Kaiser** strengthen the language in its policies and procedures to specify that reviewers *must*—not *may*—outreach to or consult with the requesting provider when appropriate.

Although **Kaiser** was able to demonstrate that members were mailed NABDs within all required time frames, the *Timeliness of UM Decision-Making and Notification* policy did not specifically state the notification time frames for denial of payment (at the time of denial of the claim); extended service authorizations (no later than the date the extension expires); and termination, suspension, or reduction of previously authorized services. HSAG recommends that the *Timeliness of UM Decision-Making and Notification* policy address the complete listing of notification time frames outlined in the requirements and, if **Kaiser** does not deny previously authorized services, that this policy clearly states so.

The *Denial of Coverage* policy listed all of the components of the CHP+ NABD as defined in the requirement *except* "the member's right to appeal under the Child Mental Health Treatment Act (CMHTA)." Although the CMHTA applies only in specific circumstances, HSAG recommends the policy address this component and contain procedures for determining when it is applicable to include the CMHTA appeal information in the NABD.

Kaiser's *Coverage of Emergency Services* policy is silent on the regulatory criteria applicable to payment of emergency services. Whereas staff members confirmed that **Kaiser** does not deny emergency services for any reason, HSAG recommends that the policy clearly state that **Kaiser** pays for all emergency service claims in or out of network without review or determination of medical necessity.

Summary of Required Actions

Kaiser's authorization policies articulated mechanisms for consulting with the requesting provider to obtain additional information when required to make an authorization decision. However, during on-site denial record reviews, HSAG identified one case in which **Kaiser** requested additional clinical information from the member's family but not from the requesting provider. **Kaiser** must ensure that reviewers consult with the requesting provider for medical services to obtain additional information to make an authorization decision.

The *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making standard and expedited authorization decisions; however, the time frame for expedited decisions inaccurately stated three business days rather than 72 hours. **Kaiser** must correct its policies and procedures to reflect the accurate time frames for making standard and expedited authorization decisions.

Kaiser's *Regulatory Timelines for Pharmacy Authorization Service Grid* provided guidance to pharmacy staff regarding authorization time frames for covered outpatient drugs. The grid inaccurately specified that, for CHP+ members, **Kaiser** must notify the member of "receipt of request" within 24 hours and process the authorization decision within 72 hours for urgent pre-service requests and within 10 calendar days for routine pre-service requests. In addition, **Kaiser** did not provide a written policy or procedures addressing this requirement. **Kaiser** must implement procedures, applicable to the CHP+ program, for providing telephonic or telecommunication notice of the *authorization decision* within 24 hours of receipt of complete information from the prescriber/requestor for making an authorization decision regarding covered outpatient drugs. In addition, **Kaiser** must submit a written policy and procedure addressing this requirement.

The NABD template language included numerous terms—"relevant," "terminated," "pre-service," "concurrent," "expeditiously," and "jeopardize"—that are beyond the sixth-grade reading level. In addition, on-site record reviews identified free text information entered into the letter (i.e., the reason for the denial) that included extensive and unnecessary clinical jargon or explanation of **Kaiser**'s rules and regulations. The appeals information in the NABD included continuation of benefits information when not applicable to the type of denial (termination or reduction of previously authorized services). HSAG found that all records included in the record review sample failed to meet the requirement, "correspondence with the member was easy to understand." **Kaiser** must simplify the content and language in the CHP+ NABD to CHP+ members to comply with sixth-grade reading level requirements (to the degree possible).

The NABD and Explanation of Benefits (EOB)—used to notify the member of denial of payment—included all required content. However, the appeals information in the NABD and EOB included several inaccuracies in current regulatory time frames and processes. Due to the numerous inaccuracies in the content of the NABD, HSAG found all records included in the record review sample failed to meet the requirement for "NABD includes required content." **Kaiser** must update the NABD and appeals information in the EOB to reflect current regulations and correct inaccuracies in appeal and State fair hearing (SFH) time frames and processes, including:

- The NABD and EOB communicated the time frame for filing an appeal is 30 calendar days (should be 60 days).

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- The NABD communicated that the time frame for determining an expedited appeal is three *business* days (should be 72 hours).
- The process for requesting a SFH in the NABD and EOB communicated that "you may request a SFH during your appeal or you can wait until after we decide your appeal" (members may request a SFH *only* following appeal resolution from the plan).
- The NABD and EOB communicated that a SFH must be requested within 30 days from the date of the NABD (should be 120 days from the appeal resolution).
- The NABD did not clearly specify that a request for continued benefits during the appeal applies only to termination or reduction of previously authorized services.
- The NABD communicated that to request continued benefits "you must *file your appeal* within 10 days of NABD (members must *request continued benefits* within 10 days; they have 60 days to file an appeal).
- The NABD communicated that continued benefits will terminate when "the time period or service limits of a previously authorized service has been met" (this criterion has been removed from federal regulations).

The *Timeliness of UM Decision-Making and Notification* policy addressed notification time frames for standard, expedited, and extended authorization decisions, as well as service authorization decisions not reached within the required time frame; however, the time frame for notice of expedited decisions inaccurately stated three business days rather than 72 hours after receipt of the request for service. **Kaiser** must correct its policies and procedures to accurately address the 72-hour time frame requirement for providing the NABD to the member for expedited authorization requests.

During on-site interviews, staff members described that poststabilization services (such as inpatient hospitalization) required prior authorization for payment, and that UM staff used established medical necessity criteria to make authorization decisions. However, **Kaiser** did not have internal processes or written procedures for application of the regulatory guidelines in determining financial responsibility for poststabilization care services that are not pre-approved. **Kaiser** must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including:

- For services administered within one hour of a request to **Kaiser** for pre-approval of poststabilization care—as defined in 42 CFR §422.113(c)(2)(ii).
- If **Kaiser** does not respond to a request for pre-approval within one hour, **Kaiser** cannot be contacted, or **Kaiser** staff and the treating physician cannot come to an agreement regarding the member's care—as defined in 42 CFR §422.113(c)(2)(iii).
- Application of the criteria for when financial responsibility ends—as defined in 42 CFR §422.113(c)(3).
- Ensuring that **Kaiser** does not charge the member more for poststabilization services delivered out of network than for services delivered in network—as defined in 42 CFR §422.113(c)(2)(iv).

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Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

Kaiser demonstrated having adequate mechanisms for maintaining and monitoring access to providers. The *Practitioner Availability and Sufficiency of Services* policy described **Kaiser**'s annual comprehensive analysis of its provider network through identification of high-volume specialties, analyzing geographic distribution of members and providers, calculating member-to-provider ratios, and assessing sufficiency of facility types (e.g., primary care, specialty care, and behavioral health). **Kaiser** completed a barrier analysis upon notification of a new or impending change in the provider network. The barrier analysis triggered the Network Adequacy team to identify the associated impact and appropriate next steps for mitigation. The Network Adequacy and Directories department performed additional assessment through routine Network Adequacy reports and quarterly CHP+ reports.

Kaiser's *Member Access to Care Policy and Procedure* provided detailed guidelines for offering convenient and alternative modes of care to members. Members had the option to choose the type of care visit most convenient for them—video visit, e-visit, or telephonic. **Kaiser** offered various telephonic options to assist members. The Appointments and Advice Call Center (AACC) and the Telephonic Medicine Center (TMC) provided members advice about nonemergency care and responded to questions about where to obtain care. **Kaiser** members could use the Telephone Advice Visit (TAV) any day of the week for same-day home advice and treatment for conditions that would otherwise require an office visit. The AACC, TMC and TAV teams consisted of registered nurses and physicians. Members received information on these services through the *CHP+ Member Handbook*, *CHP+ New Member Guide*, *CHP+ Provider Directory*, and *CHP+ Evidence of Coverage.*

Kaiser facilities offered physical accommodations to ensure sufficient member accessibility. The *Equal Access to Facilities Services and Programs* policy described access standards maintained and monitored by **Kaiser**, which were in accordance with the Americans with Disabilities Act and enabled equal access to members with physical or mental disabilities. **Kaiser** demonstrated mechanisms for overseeing exam room, parking lot, and building accessibility. **Kaiser** allowed service animals to accompany members and provided auxiliary aids and services free of charge, accessible medical equipment, mobility aids and devices free of charge, and signage for navigation assistance throughout the parking lots and inside **Kaiser** facilities. **Kaiser** used the *Kaiser Permanent Foundation Health Plan of Colorado Affiliated Contracted Provider Monitoring Checklist* (*Contracted Provider Monitoring Checklist*) to annually monitor facility and provider compliance with these standards. Members received information on these assistance services through the *CHP+ Evidence of Coverage*, *CHP+ New Member Guide*, and *CHP+ Provider Directory*. Providers are made aware of these standards and requirements through the *Provider Manual* and the *Provider Services Agreement*. The *Evaluation of Affiliated Practitioner Sites* policy described the methods and procedures for assessing office sites and how the Quality, Risk and Patient Safety department determined corrective actions for noncompliant sites.

Kaiser furnished members with multiple options for language assistance services. Language accommodations included video remote interpretive services, phone translators, and in-person

translators, all at no cost to the member. The **Kaiser** website and online provider directory informed members which providers or offices had staff proficient in specific languages. **Kaiser** also provided information on language assistance services through the *CHP+ Evidence of Coverage*, *CHP+ New Member Guide,* and *CHP+ Provider Directory.* Providers received information about these services through the *Provider Manual*.

Kaiser's *Member Access to Care Policy and Procedure* and *Practitioner Availability and Sufficiency of Services* policies documented appropriate CHP+ time and distance standards and timely access standards for primary care, specialty care, and behavioral health. **Kaiser** monitored compliance through the Network Adequacy reports, quarterly CHP+ reports, and the annual *Contracted Provider Monitoring Checklist*. **Kaiser** included all provider access requirements in the *Provider Services Agreement* and *Provider Manual*. **Kaiser** informed members of these standards in the *CHP+ Evidence of Coverage.*

Kaiser dedicated a section in the *CHP+ Provider Directory* to notifying members of **Kaiser**'s commitment to provide culturally competent care and assured members that **Kaiser** providers were trained in cultural competency. The *Commitment to Diversity and Inclusion* policy described **Kaiser**'s methods for maintaining a culturally sensitive healthcare system using five pillars—care, workforce, marketplace, supplier diversity and community partnership, and diversity and inclusion. **Kaiser** demonstrated how the internal clinical library, maintained by **Kaiser**'s Care Management Institute, offered providers and staff cultural competency continuing education options, as well as cultural and ethnic-specific clinical guidance, clinical tools, and member handouts. In addition, **Kaiser** annually provided a flyer to staff and providers, which listed available cultural competency workshops.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the 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+ denial of authorization.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ denials to evaluate implementation of federal healthcare regulations. 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 sample from all CHP+ denial records that occurred between January 1, 2019, and December 31, 2019. 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 I—Coverage and Authorization of Services. HSAG separately calculated a record review score for each record 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.[2-1] Appendix E contains a detailed description of HSAG's site review

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The health plan's compliance with federal healthcare regulations and managed care contract requirements in the two areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal 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.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 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 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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.

Related to coordination and continuity of care, **Kaiser** was required to complete two corrective actions, including:

- 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.
- 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.

Related to member rights and protections, **Kaiser** was required to 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.

Related to quality assessment and performance improvement, **Kaiser** was required to complete two corrective actions, including:

- Provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the Quality Assessment and Performance Improvement (QAPI) program and analyzed as such.

- Develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care rendered to members with special health care needs.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in March 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **Kaiser**. **Kaiser** submitted initial documents as evidence of completion in August 2019, and all required actions were found to be successfully completed.

Summary of Continued Required Actions

Kaiser successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-1—8.3	**#1. 2019 KFHP Quality Program Description Final 2019** **#2. 2019 Regional Resource Stewardship Utilization Management Program Description,** Purpose and Goals, page 4. These reports demonstrate that the Kaiser Permanente Colorado monitors the services provided to all our members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-1—8.11	**#3. Authorization of Services Policy ID#: 6891-13, Page 2, paragraph 5** Except where required by the CHP+ contract, CHP members receive the same access to services in terms of timeliness, amount, duration and scope as members of other lines of business.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. – Long-term services and supports (LTSS) supporting individuals with ongoing or chronic conditions are	**#4. Medical Necessity Criteria, Policy ID #: 6891-14** (Medical Necessity Criteria18.pdf). **#3. Authorization of Services, Policy ID #: 6891-13** (Authorization of Services18.pdf). See Policy Statement, paragraph 2 and highlighted section on page 3 – demonstrates review for medical necessity. **#5. CHP+ Evidence of Coverage 2019, Family Planning, Section H, page 17**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
authorized in a manner that reflects the member's ongoing need for such services. *42 CFR 438.210(a)(4)* Contract: Exhibit B-1—8.15.8.1		
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3—10-16-104(3)(B)* Contract: Exhibit B-1—8.15.4.1		*For Information Only*
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*		*For Information Only*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor specifies what constitutes "medically necessary" in a manner that is: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition. • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence. • Not experimental, investigational, unproven, unusual, or not customary. • Not solely for cosmetic purposes. • Not solely for the convenience of the member, subscriber, physician, or other provider. • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health. • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting. Contract: Exhibit B-1—1.1.62.1–8	**#3. Authorization of Services, Policy ID #: 6891-13** (Authorization of Services18.pdf). See Policy Statement, paragraph 2 (highlighted); and Page 2, paragraph 1: *Benefits are no more restrictive in amount, duration and scope than that used in the Medicare and State Medicaid program as indicated in state statutes and regulations and the State Plan for Senior Advantage, CHP+ and Access KP covered persons.* **#5. CHP+ Evidence of Coverage 2019**–Medically Necessary definition, pgs 40-41 **#4. Medical Necessity Criteria, Policy ID #: 6894-14**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-1—11.1.5 and its subcontractors is new	**#3. Authorization of Services, Policy ID #: 6891-13**. See Procedure to Implement Policy, pages 4-6 – demonstrate process for requesting authorization of services. **#8. CHP+ ContinuationofCare18** KPCO does not delegate utilization management to subcontractors in the Denver/Boulder Service Area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-1—11.1.6	**#9. Monitoring of Reviewer Reliability, Policy ID #: 6891-15.** See Policy Statement. Demonstrates how Kaiser Permanente Colorado monitors staff for consistency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-1—11.1.6	**#3. Authorization of Services, Policy ID #: 6891-13** (Authorization of Services18.pdf). See Policy Statement, pg 2, paragraph 1. Demonstrates process for physician consultation. **#12. Responsibilities of CPMG Physician and Medical Personnel for UM, Policy ID #: 6891-19.**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
Kaiser's authorization policies articulated mechanisms for consulting with the requesting provider to obtain additional information when required to make an authorization decision. However, during on-site denial record reviews, HSAG identified one case in which Kaiser requested additional clinical information from the member's family but not from the requesting provider.

Required Actions:
Kaiser must ensure that reviewers consult with the requesting provider for medical services to obtain additional information when appropriate. HSAG also recommends that Kaiser strengthen the language in its policies and procedures to specify that reviewers *must*—not *may*—outreach to or consult with the requesting provider when appropriate.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-1—11.1.3	**#3. Authorization of Services, Policy ID #: 6891-13** (Authorization of Services18.pdf). See Policy Statement, pg 2, paragraph 2. Demonstrates process for seeking clinical expertise during decision making. **#11. Denial of Coverage, Policy ID #: 6891-12** (Denial of Coverage18.pdf) See Policy Statement, pg 1, paragraph 3. Demonstrates process for seeking clinical expertise during decision making. **#10. Affirmation Statement for Board Certification, Policy ID #: 6891-02** (Affirmation Statement of Board Certification18.pdf**)**. See Policy Statement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-1—11.1.8	**#3. Authorization of Services, Policy ID #: 6891-13** Procedure to Implement Policy, pages 5 and 6. Demonstrates authorization notification regarding amount, duration and scope. **#11. Denial of Coverage, Policy ID #: 6891-12**, Policy Statement, page 2, paragraph 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain	**#6. Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (Timeliness of UM DecisionMaking18.pdf). See highlighted section: • **Standard** – page 3, last paragraph • **Expedited** – page 6, paragraphs 4-5	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12		
Findings: The *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making standard and expedited authorization decisions; however, the time frame for expedited decisions inaccurately stated three business days rather than 72 hours.		
Required Actions: Kaiser must correct its policies and procedures to reflect the accurate time frames for making standard and expedited authorization decisions.		
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-1—11.1.10.1–2; 11.1.12.1–2	**#6. Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** See page 3, last paragraph.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(c)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	**#7. Regulatory Timelines for Pharmacy Authorization Service Grid** Pharmacy team adheres to the timelines outlined in this document for processing CHP+ covered outpatient drugs.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Kaiser's *Regulatory Timelines for Pharmacy Authorization Service Grid* provided guidance to pharmacy staff regarding authorization time frames for covered outpatient drugs. The grid inaccurately specified that, for CHP+ members, Kaiser must notify the member of "receipt of request" within 24 hours and process the authorization decision within 72 hours for urgent pre-service requests and within 10 calendar days for routine pre-service requests. In addition, Kaiser did not provide a written policy or procedures addressing this requirement.		
Required Actions: Kaiser must implement procedures, applicable to the CHP+ program, for providing telephonic or telecommunication notice of the *authorization decision* within 24 hours of receipt of complete information from the prescriber/requestor for making an authorization decision regarding covered outpatient drugs. In addition, Kaiser must submit a written policy and procedure addressing this requirement.		
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	**#13. Notice of Action – CHP+ Denial, Medical Necessity** **#14. Notice of Action – Benefit Denial with Appeal Rights** **#15. CATLAR Notice of language assistance** Demonstrates state specific non-English language assistance letter added to all essential member communications. **#5. CHP+ Evidence of Coverage 2019**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The notice of adverse benefit determination (NABD) template language included numerous terms—"relevant," "terminated," "pre-service," "concurrent," "expeditiously," and "jeopardize"—that are beyond the sixth-grade reading level. In addition, on-site record reviews identified free text information entered into the letter (i.e., the reason for the denial) that included extensive and unnecessary clinical jargon or explanation of Kaiser's rules and regulations. The		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
appeals information in the NABD included continuation of benefits information when not applicable to the type of denial (termination or reduction of previously authorized services). HSAG found that all records included in the record review sample failed to meet the requirement, "correspondence with the member was easy to understand." HSAG recommends that Kaiser consider developing a specific CHP+ member template and implement a mechanism to review autogenerated NABD letter content for clarity prior to mailing the NABD to the member.		
Required Actions: Kaiser must simplify the content and language in the CHP+ NABD to comply with sixth-grade reading level requirements (to the degree possible).		
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request	**#11. Denial of Coverage, Policy ID #: 6891-12**, Policy Statement, page 3, #1 **#13. Notice of Action – CHP+ Denial, Medical Necessity** **#14. Notice of Action – Benefit Denial with Appeal Rights**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12		

Findings:
Kaiser's *Denial of Coverage* policy listed all of the components of the CHP+ NABD as defined in the requirement *except* "the member's right to appeal under the CMHTA, when applicable." The NABD and Explanation of Benefits (EOB)—used to notify the member of denial of payment—included all required content. However, the appeals information in the NABD and EOB included several inaccuracies in current regulatory time frames and processes, including:

- The NABD and EOB communicated that the time frame for filing an appeal is 30 calendar days (should be 60 days).
- The NABD communicated the time frame for determining an expedited appeal is three *business* days (should be 72 hours).
- The process for requesting a State fair hearing (SFH) in the NABD and EOB communicated that "you may request a SFH during your appeal or you can wait until after we decide your appeal" (members may request a SFH *only* following appeal resolution from the plan).
- The NABD and EOB communicated that a SFH must be requested within 30 days from the date of the NABD (should be 120 days from the appeal resolution).
- The NABD did not clearly specify that a request for continued benefits during the appeal applies only to termination or reduction of previously authorized services.
- The NABD communicated that to request continued benefits "you must *file your appeal* within 10 days of NABD" (members must *request continued benefits* within 10 days; they have 60 days to file an appeal).
- The NABD communicated that continued benefits will terminate when "the time period or service limits of a previously authorized service has been met" (this criterion has been removed from federal regulations).

Due to the numerous inaccuracies in the content of the NABD template information, HSAG found that all records included in the record review sample failed to meet the requirement for "NABD includes required content."

Required Actions:
Kaiser must update the NABD and appeals information in the EOB to reflect current regulations and correct the inaccuracies in appeal and SFH time frames and processes (as noted above).

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: None		*For Information Only*
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service.	**#6. Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06**, pages 5, 6 and 7. **#5. CHP+ Evidence of Coverage,** pages 5 and 6. **#3. Authorization of Services, Policy ID #: 6891-13,** Policy Statement, page 2, paragraph 4. Demonstrates once preauthorized, benefits cannot be retrospectively denied.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7		
Findings: The *Authorization of Services* policy and staff members stated that preauthorized services cannot be retrospectively denied; therefore, the *Timeliness of UM Decision-Making and Notification* policy appropriately omitted the notification requirement for termination, reduction, or suspension of previously authorized services. The National EOB Process flowchart and sample CHP+ EOB denial notice demonstrated that Kaiser autogenerated the EOB simultaneously with processing the claim. The *Timeliness of UM Decision-Making and Notification* policy addressed notification time frames for standard, expedited, and extended authorization decisions, as well as service authorization decisions not reached within the required time frame; however, the time frame for notice of expedited decisions inaccurately stated three business days rather than 72 hours after receipt of the request for service.		
Required Actions: Kaiser must correct its policies and procedures to accurately address the 72-hour time frame requirement for providing the NABD to the member for expedited authorization requests.		
20. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: − The Agency has factual information confirming the death of a member. − The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives	**#6. Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06**, pages 5, 6 and 7. **#5. CHP+ Evidence of Coverage,** pages 5 and 6. **#3. Authorization of Services, Policy ID #: 6891-13,** Policy Statement, page 2, paragraph 4. Demonstrates once preauthorized, benefits cannot be retrospectively denied.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-1—14.1.3.15.2.1–3		

Findings:
The *Authorization of Services* policy and on-site interviews confirmed that Kaiser never terminates or reduces benefits that have been previously authorized by Kaiser; therefore, HSAG scored this requirement *Not Applicable*.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-1—14.1.3.15.2.5.2	**#6. Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06,** page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-1—11.1.1	**#11. Denial of Coverage, Policy ID #: 6891-12,** Policy Statement, page 1, paragraph 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.31	**#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, paragraph 4, pages 1-2. This document supplies the definition.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.32	**#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.75	**#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review. **#5. CHP+ Evidence of Coverage, page 15** Emergency Services, a. After Your Emergency is Stabilized	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor does not require prior authorization for emergency services or urgently needed services. Contract: Exhibit B-1—8.17.1.3	**#5. CHP+ Evidence of Coverage, pages 16017** **#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, page 2, paragraph 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-1—8.17.1.4	**#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, paragraphs 2 and 3, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-1—8.17.1.4, 8.17.1.6	**#5. CHP+ Evidence of Coverage,** page 15, also see Definitions, Emergency Medical Condition Emergency and Emergency Services on page 40 **#16. Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, paragraph 4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-1—8.17.3.3, 8.20.1, 8.17.1.7	**#5. CHP+ Evidence of Coverage**, #1 – Emergency Services on page 15. Also see Definitions, Emergency Medical Condition Emergency and Emergency Services, page 40 #16. **Coverage of Emergency Services Policy ID #: 6891-03,** Policy Statement, page 2, paragraph 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-1—8.17.1.8	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
31. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-1—8.17.1.5	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review **#5. CHP+ Evidence of Coverage,** Emergency Services, a. After Your Emergency is Stabilized (Post-Stabilization) on page 15	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B-1—8.17.4.6	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2 KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: During on-site interviews, staff members described that poststabilization services (such as inpatient hospitalization) required prior authorization for payment, and that UM staff used established medical necessity criteria to make authorization decisions. However, Kaiser did not have internal processes or written procedures for application of the regulatory guidelines in determining financial responsibility for poststabilization care services that are not pre-approved.		
Required Actions: Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including for services administered within one hour of a request to Kaiser for pre-approval of poststabilization care—as defined in 42 CFR 422.113(c)(2)(ii).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B-1—8.17.4.7	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Kaiser did not have internal processes or written procedures for application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.		
Required Actions: Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including these circumstances: Kaiser does not respond to a request for pre-approval within one hour, Kaiser cannot be contacted, or Kaiser staff and the treating physician cannot come to an agreement regarding the member's care—as defined in 42 CFR 422.113(c)(2)(iii).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Kaiser did not have internal processes or written procedures for application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.		
Required Actions: Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including application of the criteria for when financial responsibility ends—as defined in 42 CFR 422.113(c)(3).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B-1—8.17.4.8	**#16. Coverage of Emergency Services Policy ID #: 6891-03**, Policy Statement, page 2, paragraph 2 KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Kaiser did not have internal processes or written procedures for the application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.		
Required Actions: Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including ensuring that Kaiser does not charge the member more for poststabilization services delivered out of network than for services delivered in network—as defined in 42 CFR 422.113(c)(2)(iv).		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	5	X	.00	=	0
	Not Met	=	5	X	.00	=	0
	Not Applicable	=	5	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	21
				Total Score ÷ Total Applicable		=	68%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: • Physicians • Specialists • Hospitals • Pharmacies • BH providers • LTSS providers, as appropriate *42 CFR 438.206(b)(1)* Contract: Exhibit B-1—7.13.1, 14.1.3.6	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09,** Provision 5.0 on pages 4 & 5. This policy identifies how the company evaluates the availability of practitioners and provider performance to the standards. The process through which the company monitors availability is provided. **#2. Kaiser Permanente Colorado Provider Directory Accuracy Report 2019 –** Attestation process, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new CHP+ members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members.	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09** See Purpose on 1 and Provisions on page 4 & 5 **#5. Provider Directory, page 2 –** Convenient Care, Page 4, Preferred Language, ADA, CATLAR **#17. CHP+ Membership and Provider Map.pdf** **#18. MOB Map.pdf**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-1—7.13.2.2.1		
3. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09** Pages 8-11	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.10		
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09** Page 11	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B1—10.2.1.11.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1		
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-1—10.2.1.15	**#6. CHP+ Evidence of Coverage 2019** Page 5, #2 - Specialty Self-Referrals	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-1—10.2.1.16	**#6. CHP+ Evidence of Coverage 2019** Page 5, #3 Second Opinions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-1—10.2.2.1	**#6. CHP+ Evidence of Coverage 2019** Page 5 Section B. Referrals, #2 Specialty Self-Referrals **#4. Authorization of Services, Policy ID #: 6891-13**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-1—10.2.2.2	**#10. KFHP External Provider Contract Template** Page 9, Section 3.3 Member Hold Harmless	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: None	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09** **#6. CHP+ Evidence of Coverage 2019,** Page 17 Section H, Family Planning Services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09,** Page 13 **#6. CHP+ Evidence of Coverage 2019,** Page 7, Appointment Scheduling Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-1—10.2.1.5–7	**#3. CHP+ Member Guide,** Urgent Care Hours **#9. KP.org Example of hours** (screenshot)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-1—10.2.4.1	**#6. CHP+ Evidence of Coverage 2019 Page** 7, Section F, Getting the Care You Need.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	**#1. Practitioner Availability and Sufficiency of Services Policy Number: 7204-09**, page 13 **#11. Member Access to Care Policy and Procedure Policy ID #7204-07** **#14. 2019331 KP CHP Quarterly Report Fiscal Q4 Apr-Jun 2019_resubmission**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members.	**#5. Provider Directory, page 2 –** Convenient Care, Page 4, Preferred Language, ADA, CATLAR **#8. CATLAR Notice of language assistance** Demonstrates state specific non-English language assistance letter added to all essential member communications (e.g. Evidence of Coverage, Explanation of Benefits). **#6. CHP+ Evidence of Coverage** See Contact Us, Nondiscrimination, Section B. General Policy Provisions **#13. Diversity Training Overview 2018** This document illustrates the diversity training requirements for Kaiser Permanente CO employees. **#15. Commitment to Diversity & Inclusion Policy** **#16. Equal Access to Facilities Services and Programs**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13		
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-1—10.8.2.10	**#5. Provider Directory, page 2,** Convenient Care, Page 4, Preferred Language, ADA, CATLAR **#15. Commitment to Diversity & Inclusion Policy** **#16. Equal Access to Facilities Services and Programs**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Provider Network Strategic Plan is submitted to the State annually. • A Provider Network Capacity and Services Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-1—15.3.1, 15.3.2	**#2. Kaiser Permanente Colorado Provider Directory Accuracy Report 2019 (Network Strategic Plan)** **#14. 2019331 KP CHP Quarterly Report Fiscal Q4 Apr-Jun 2019_resubmission** **#17. CHP+ Membership and Provider Map.pdf** **#18. MOB Map.pdf**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	December 4, 2019
Reviewer:	Kathy Bartilotta and Dara Dameron
Participating Plan Staff Member(s):	Thuyloan Giang and Stephanie Gillan

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	1/10/19	2/4/19	3/11/19	4/5/19	5/7/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	S	S
Date notice of adverse benefit determination (NABD) sent	1/18/19	2/5/19	3/11/19	4/9/19	5/8/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	8	1	0	4	1
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	NM	NM	NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NM	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	NM	NM	NM
Total Applicable Elements	**7**	**6**	**6**	**6**	**6**
Total Met Elements	**4**	**4**	**4**	**4**	**4**
Score (Number Met / Number Applicable) = %	**57%**	**67%**	**67%**	**67%**	**67%**

* = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 1: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and State fair hearing (SFH), In addition, the reason for the denial includes extensive clinical jargon quoted from the criteria used for the determination and is not easy for the member to understand. While the reviewer notes included several clinical questions that required more information, the reviewers requested more information from the member's parent, rather than from the requesting provider.

File 2: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

File 3: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

File 4: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

File 5: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	OMIT	****	OMIT	****	****
Date of initial request		6/18/19		7/9/19	8/20/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])		NR		NR	NR
(Standard [S], Expedited [E], or Retrospective [R])		S		S	S
Date notice of adverse benefit determination (NABD) sent		6/28		7/16	8/28
Notice sent to provider and member? (M or NM)*		M		M	M
Number of days for decision/notice		10		7	8
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*		M		M	M
Was authorization decision timeline extended? (Y or N)		N		N	N
If extended, extension notification sent to member? (M, NM, or NA)*		NA		NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*		NA		NA	NA
NABD includes required content? (M or NM)*		NM		NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*		M		M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*		NA		NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*		M		M	M
Was correspondence with the member easy to understand? (M or NM)*		NM		NM	NM
Total Applicable Elements		**6**		**6**	**6**
Total Met Elements		**4**		**4**	**4**
Score (Number Met / Number Applicable) = %		**67%**		**67%**	**67%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: Record omitted because the denial was due to "member not a plan participant on the date of services requested."

File 7: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

File 8: Record omitted because the denial was due to "member not currently a plan participant."

File 9: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

File 10: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****	****			
Date of initial request	2/25/19	4/25/19			
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR			
(Standard [S], Expedited [E], or Retrospective [R])	S	S			
Date notice of adverse benefit determination (NABD) sent	3/4	5/2			
Notice sent to provider and member? (M or NM)*	M	M			
Number of days for decision/notice	7	7			
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M			
Was authorization decision timeline extended? (Y or N)	N	N			
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA			
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA			
NABD includes required content? (M or NM)*	NM	NM			
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M			
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA			
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M			
Was correspondence with the member easy to understand? (M or NM)*	NM	NM			
Total Applicable Elements	**6**	**6**			
Total Met Elements	**4**	**4**			
Score (Number Met / Number Applicable) = %	**67%**	**67%**			

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File OS 1: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language. In addition, the file demonstrated that the patient and parents were Spanish-speaking only and had a translator present at appointments; however, the NABB was sent in English, not Spanish.

File OS 2: All required elements are included in the content of the letter; however, the information in the appeals attachment is inaccurate regarding the time frames for filing an appeal and SFH. In addition, the reason for the denial (services available from a KP provider) included extensive explanation of KP's regulations and processes which were *not* written in plain language.

Total Record Review Score*	**Total Applicable Elements: 61**	**Total Met Elements: 40**	**Total Record Review Score: 66%**

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **Kaiser**.

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

HSAG Review Team	Title
Katherine Bartilotta	Associate Director
Dara Dameron	Project Manager
Kaiser Participants	**Title**
Carlos Madrid	Senior Manager, Medicaid & Charitable Programs
Cathy Johnson	Regulatory Consultant, Medicaid & Charitable Programs
Janet Lucchesi	Director of Quality and Accreditation Oversight
Jennifer Boyle (telephonic)	Colorado First Pass Supervisor (Claims)
Jim Shelton (telephonic)	Claims Processing Director
Kathy Westcoat	Senior Director, Medicaid & Charitable Programs
Kirsten Swart	Compliance Consultant, Government Programs
Liz Chapman	Project Manager, Medicaid & Charitable Programs
Mikala Gibbs (telephonic)	Manager, NOSA (Network Adequacy & Directories)
Robin Dam	Compliance Auditor
Sara Tracy (telephonic)	Hospital Services Director
Stephanie Gillan	UM Regulatory Coordinator, Resource Stewardship
Thuyloan Giang	UM Regulatory Manager, Resource Stewardship
Department Observers	**Title**
Russ Kennedy	HCPF—Quality Program Manager
Teresa Craig (telephonic)	HCPF—Contract Manager

Appendix D. Corrective Action Plan Template for FY 2019–2020

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 2019–2020 Corrective Action Plan for Kaiser

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-1—11.1.6	Kaiser's authorization policies articulated mechanisms for consulting with the requesting provider to obtain additional information when required to make an authorization decision. However, during on-site denial record reviews, HSAG identified one case in which Kaiser requested additional clinical information from the member's family but not from the requesting provider. HSAG recommends that Kaiser strengthen the language in its policies and procedures to specify that reviewers *must*—not *may*—outreach to or consult with the requesting provider when appropriate.	Kaiser must ensure that reviewers consult with the requesting provider for medical services to obtain additional information when appropriate.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12	The *Timeliness of UM Decision-Making and Notification* policy addressed time frames for making standard and expedited authorization decisions; however, the time frame for expedited decisions inaccurately stated three business days rather than 72 hours.	Kaiser must correct its policies and procedures to reflect the accurate time frames for making standard and expedited authorization decisions.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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Requirement	**Findings**	**Required Action**
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(c)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	Kaiser's *Regulatory Timelines for Pharmacy Authorization Service Grid* provided guidance to pharmacy staff regarding authorization time frames for covered outpatient drugs. The grid inaccurately specified that, for CHP+ members, Kaiser must notify the member of "receipt of request" within 24 hours and process the authorization decision within 72 hours for urgent pre-service requests and within 10 calendar days for routine pre-service requests. In addition, Kaiser did not provide a written policy or procedures addressing this requirement.	Kaiser must implement procedures, applicable to the CHP+ program, for providing telephonic or telecommunication notice of the *authorization decision* within 24 hours of receipt of complete information from the prescriber/requestor for making an authorization decision regarding covered outpatient drugs. In addition, Kaiser must submit a written policy and procedure addressing this requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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Requirement	**Findings**	**Required Action**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	The notice of adverse benefit determination (NABD) template language included numerous terms—"relevant," "terminated," "pre-service," "concurrent," "expeditiously," and "jeopardize"—that are beyond the sixth-grade reading level. In addition, on-site record reviews identified free text information entered into the letter (i.e., the reason for the denial) that included extensive and unnecessary clinical jargon or explanation of Kaiser's rules and regulations. The appeals information in the NABD included continuation of benefits information when not applicable to the type of denial (termination or reduction of previously authorized services). HSAG found that all records included in the record review sample failed to meet the requirement, "correspondence with the member was easy to understand." HSAG recommends that Kaiser consider developing a specific CHP+ member template and implement a mechanism to review autogenerated NABD letter content for clarity prior to mailing the NABD to the member.	Kaiser must simplify the content and language in the CHP+ NABD to comply with sixth-grade reading level requirements (to the degree possible).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review.	Kaiser's *Denial of Coverage* policy listed all of the components of the CHP+ NABD as defined in the requirement *except* "the member's right to appeal under the CMHTA, when applicable." The NABD and Explanation of Benefits (EOB)—used to notify the member of denial of payment—included all required content. However, the appeals information in the NABD and EOB included several inaccuracies in current regulatory time frames and processes, including: • The NABD and EOB communicated that the time frame for filing an appeal is 30 calendar days (should be 60 days). • The NABD communicated the time frame for determining an expedited appeal is three *business* days (should be 72 hours). • The process for requesting a State fair hearing (SFH) in the NABD and EOB communicated that "you may request a SFH during your appeal or you can wait until after we decide your appeal" (members may request a SFH *only* following appeal resolution from the plan). • The NABD and EOB communicated that a SFH must be requested within 30 days	Kaiser must update the NABD and appeals information in the EOB to reflect current regulations and correct the inaccuracies in appeal and SFH time frames and processes, as noted in the findings.

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Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12	from the date of the NABD (should be 120 days from the appeal resolution). • The NABD did not clearly specify that a request for continued benefits during the appeal applies only to termination or reduction of previously authorized services. • The NABD communicated that to request continued benefits "you must *file your appeal* within 10 days of NABD" (members must *request continued benefits* within 10 days; they have 60 days to file an appeal). • The NABD communicated that continued benefits will terminate when "the time period or service limits of a previously authorized service has been met" (this criterion has been removed from federal regulations). Due to the numerous inaccuracies in the content of the NABD template information, HSAG found that all records included in the record review sample failed to meet the requirement for "NABD includes required content."	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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Requirement	**Findings**	**Required Action**
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7	The *Authorization of Services* policy and staff members stated that preauthorized services cannot be retrospectively denied; therefore, the *Timeliness of UM Decision-Making and Notification* policy appropriately omitted the notification requirement for termination, reduction, or suspension of previously authorized services. The *Timeliness of UM Decision-Making and Notification* policy addressed notification time frames for standard, expedited, and extended authorization decisions, as well as service authorization decisions not reached within the required time frame; however, the time frame for notice of expedited decisions inaccurately stated three business days rather than 72 hours after receipt of the request for service.	Kaiser must correct its policies and procedures to accurately address the 72-hour time frame requirement for providing the NABD to the member for expedited authorization requests.

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Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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Requirement	**Findings**	**Required Action**
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* Contract: Exhibit B-1—8.17.4.6	Kaiser did not have internal processes or written procedures for application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.	Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including for services administered within one hour of a request to Kaiser for pre-approval of poststabilization care—as defined in 42 CFR 422.113(c)(2)(ii).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B-1—8.17.4.7	Kaiser did not have internal processes or written procedures for application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.	Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including these circumstances: Kaiser does not respond to a request for pre-approval within one hour, Kaiser cannot be contacted, or Kaiser staff and the treating physician cannot come to an agreement regarding the member's care—as defined in 42 CFR 422.113(c)(2)(iii).

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Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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Requirement	**Findings**	**Required Action**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	Kaiser did not have internal processes or written procedures for application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.	Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including application of the criteria for when financial responsibility ends—as defined in 42 CFR 422.113(c)(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:		

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Requirement	**Findings**	**Required Action**
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B-1—8.17.4.8	Kaiser did not have internal processes or written procedures for the application of the regulatory guidelines for determining financial responsibility for poststabilization care services that are not pre-approved.	Kaiser must develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including ensuring that Kaiser does not charge the member more for poststabilization services delivered out of network than for services delivered in network—as defined in 42 CFR 422.113(c)(2)(iv).
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:		

HSAG HEALTH SERVICES ADVISORY GROUP

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 two standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (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 denials. • 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 2019–2020 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 Department**
	• 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.