Fiscal Year 2020–2021 Site Review Report

for

Kaiser Permanente

January 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the 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, Title 42 (42 CFR)—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) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Scored	Score* (% of Met Elements)
V. Member Information Requirements	21	21	19	2	0	0	90%
VI. Grievance and Appeal Systems	34	33	23	10	0	1	70%
VII. Provider Participation and Program Integrity	16	16	16	0	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**74**	**61**	**13**	**0**	**1**	**81%**

*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. Some items were marked as "Not Scored" due to regulation changes which came into effect in December 2020.

Table 1-2 presents the scores for **Kaiser** for the grievance and appeal 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)
Grievances	60	54	53	1	6	98%
Appeals	54	47	45	2	6	96%
Totals	**114**	**101**	**98**	**3**	**12**	**97%**

*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 V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

Kaiser conducted outreach to CHP+ members at enrollment and annually by mailing a postcard to each member, parent, or guardian that included the online location of the Evidence of Coverage (EOC) as well as offered a printed copy if the member returned an attached self-addressed postage-paid postcard. The EOC contained a comprehensive set of information: benefits; member rights; grievance and appeal processes; provider selection; and email, chat, and e-visit options for medical appointments. The member benefit information addressed copayments, emergency transport and the right to access emergency care at any hospital or emergency setting, advance directives, how to obtain translation services and other auxiliary aids, and fraud and abuse reporting.

Kaiser staff members stated that, prior to the annual postcard mailing, the EOC and other member information materials were verified for accuracy and changes were incorporated into the EOC and **Kaiser**'s technical systems where necessary. In addition, **Kaiser** developed a New Member Guide that summarized key information and phone numbers, including how to obtain appointments; support for ongoing conditions; information about preventive care, wellness, and mental health; and pharmacy benefits. Of note was the addition of a *New Member Connect* phone number that offered assistance with any questions.

In calendar year (CY) 2020, **Kaiser** began developing a new website designed to be more user-friendly and, at the time of the audit, was in the process of updating materials to direct CHP+ members to the new site. During the webinar interview, **Kaiser** staff members estimated that the project would be completed in CY 2021. The current website contained a provider search function, a formulary, benefit information, downloadable Portable Document Format (PDF) documents, and information about interpretation services that were depicted as free of charge. Several of the website documents were enabled with read-aloud functionality. Information on programs and classes was available, along with online health and drug encyclopedias as learning resources.

Kaiser provided examples of letters notifying members of significant changes 30 days prior to the change and contracted primary and specialty care provider terminations within 15 days of **Kaiser** notification from or to the provider. Essential information was present in the provider directory, including disability accommodations and spoken languages.

Summary of Findings Resulting in Opportunities for Improvement

Although the use of sixth grade language may not always be possible when conveying certain required information (i.e., covered benefits), HSAG recommends updating member documents with member-friendly language wherever possible.

HSAG recommends **Kaiser** review documents for consistency in language, such as the use of "adverse benefit determination" vs. "notice of action," which were used interchangeably in the benefit denial letter template, grievance and appeal policy, and EOC, and may confuse the reader.

Kaiser's EOC did not include a tagline prominently positioned at the beginning of the document and, while the narrative in other languages included a contact phone number, the large print English statement did not. Taglines were not present in the New Member Guide and not all taglines were in 18-point font. However, due to CMS revised Medicaid and CHIP regulations posted November 13, 2020, the federal requirement has since changed the definition of "large font" from 18-point font to "conspicuously visible." HSAG recommends that **Kaiser** review key member documents to ensure taglines and large fonts are prominently placed and consistently include required content.

Kaiser's website had a variety of useful resources for members; however, locating specific CHP+ information on the current website was complicated and may be confusing for members. Although some of this confusion was due to the ongoing project to update and transition from an old website to a new one, HSAG recommends, where possible, adding a direct link on member information to the specific CHP+ website pages and/or from the old website to the new CHP+ website.

Summary of Required Actions

While some of **Kaiser**'s CHP+ member information materials were written in easy-to-read language, Flesch-Kincaid grade level testing showed results ranging from the ninth through eleventh grade. These documents included the EOC booklet, the initial pages of the formulary, the benefit denial letter, and the physician retirement letter. **Kaiser** must implement a process to regularly review member information documents and simplify language, where possible, to ensure materials are easily understood.

Language regarding the five-business day response time frame for documents requested in paper form was included in the EOC, New Member Guide, and the new member postcard. While the majority of **Kaiser**'s operational processes for annual member information updates and outreach were comprehensive, the requirement for the five-business day response for sending member information in paper form when requested was not included in **Kaiser**'s desktop procedure or in the delegated vendor's distribution of materials agreement. Additionally, compliance with Section 508 guidelines varied. The Web Accessibility Evaluation Tool (WAVE) identified errors on webpages of the KP.org website, including the landing page for finding a region (i.e., Denver/Boulder) and the landing page to search for providers. HSAG found several accessibility errors in **Kaiser**'s provider directory PDF, EOC, and formulary documents.

Kaiser must revise internal procedures to ensure a five-business day response time for member information paper document requests (i.e., EOC). **Kaiser** must also develop a process for regular testing of PDF documents available to members to ensure these documents meet accessibility requirements, and also to ensure that all member-related website information complies with Section 508 specifications for accessibility (i.e., Section 508 of Section 504 of the Rehabilitation Act and World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines).

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

Kaiser operated a local Complaint, Grievance, and Appeal (CGA) team to address CHP+ issues. This team was supported by corporate level policies, procedures, and software systems such as the Member Experience Tracking and Reporting System (MTRS), which had been implemented since the last grievance and appeal systems review. This software connectivity at a corporate level allowed all issues to be logged in a centralized system but investigated and resolved at a local level for the CHP+ population. Staff members reported that the MTRS tracked grievance and appeal cases from beginning to end, produced alerts for investigation and resolution time frames, and allowed for a range of reporting capabilities.

In addition to local CGA staff members, clinical support was reported to be available in the local Colorado offices or through physician consultants in the utilization management (UM) department. Issues could also be sent to the quality department for review, if necessary. **Kaiser** ensured comprehensive clinical review by soliciting specific feedback from the clinical reviewer. For example, if the issue involved access to care, the grievance and appeal staff may ask for a recommended timeline to schedule the next appointment; or, for an issue regarding treatment, they may request feedback regarding alternatives or next steps.

Kaiser's grievance and appeal policy and the EOC included most of the required information in an accurate manner. Documents accurately explained time frames for acknowledgement, expedition, extensions, and resolutions of grievances and appeals. Policies and procedures included extensive details to support staff members in decision making and documentation. Grievance and appeal samples and templates included required information regarding translation, teletypewriter (TTY), and toll-free numbers. **Kaiser** demonstrated strengths in the grievance record review with 10 of 10 records in compliance for timely grievance acknowledgement letters, nine of 10 records containing member-friendly language, and clinical reviews being conducted when applicable. Furthermore, **Kaiser** implemented additional attachments to update State fair hearing (SFH) time frames, which had been extended due to the coronavirus disease 2019 (COVID-19) pandemic and, at the time of this report, allowed members up to 240 days to request an SFH.

Summary of Findings Resulting in Opportunities for Improvement

While the definition of "grievance" within both policy and member-facing information was accurate, one training document, *Complaint Handling Participant Guide*, contained inconsistencies, such as stating, "In some cases, a grievance can be solely a request for referral, provision of or reimbursement for services or supplies with no expression of dissatisfaction. In addition, a request for a sooner appointment which may adversely or may not affect the member."

Staff members described MTRS as having the functionality to recognize a member's insurance type and auto-fill the corresponding correct filing time information into denial, grievance, and appeal templates.

However, the appeal records showed inconsistencies in terms of timelines depicted in two notice of adverse benefit determination (NABD) letters and one example of a denied request for an expedited appeal resolution, which was transferred to the standard time frame. HSAG recommends implementing additional quality assurance steps to verify that information placed within **Kaiser** template letters corresponds to CHP+ requirements.

Staff members described rationale that **Kaiser** used a 15-calendar day timeline for resolving all grievances in order to streamline procedures; however, member documents still reflected the 15-business day timeline. While the calendar day approach was within the required timeliness, record samples showed that six of the 10 grievances were beyond the internal process of 15 calendar days. HSAG recommends that **Kaiser** ensure consistent application and compliance with internal policies.

Within member grievance acknowledgement letters, **Kaiser** staff members included language such as "I tried to call you on <date>, if you still haven't connected with me via phone, please call me at…." HSAG noted this is a helpful way to both offer assistance and provide an opportunity to collect additional information about the case. HSAG recommends utilizing similar language within appeal templates. An additional recommendation for the appeal acknowledgement process is to add a check for staff members to see if the appeal filing time frame has expired. In one record review instance, an acknowledgement letter was mailed and shortly after a resolution letter was sent stating the time frame had expired to file the appeal; HSAG recommends as best practice to check time frames at the time of receipt.

Summary of Required Actions

Kaiser's definition for "adverse benefit determination" included all the required criteria within the grievance and appeal policy; however, the definition was incomplete in the member-facing materials. Specifically, it lacked the definition elements that an NABD includes "the failure to provide services in a timely manner, as defined by the State" and "the denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other)." Additionally, within the provider manual the term "adverse organization determination" was used rather than "adverse benefit determination." **Kaiser** must update member-facing information to include the complete federal and CHP+ definition of "adverse benefit determination."

Kaiser's policy accurately stated that a member may file a grievance at any time; however, a section of the policy contained limitations regarding how many times the member can file a grievance. Section 6.1.7 stated, "Members or their authorized representative, have the right to file a repeat grievance on an issue and/or request that was previously resolved. A repeat grievance is allowed anytime if a member is unhappy with their initial complaint resolution, after which the member is considered to have exhausted internal Plan options." While **Kaiser** included that a member may request an external review by the Department, this language appeared much later in the policy and the "repeat grievance" definition still inaccurately described grievance limitations. **Kaiser** must update policies and any related documents to clarify that CHP+ members may file a repeat appeal without restriction.

Nine of the 10 grievance resolution letters HSAG reviewed were written in a language that would be easy for a member to understand. However, in sample grievance number two, the grievance resolution letter in its entirety was written at an eleventh grade reading level, and the specific grievance disposition was written at a thirteenth grade reading level, including terms such as "Sr Manager of Digital Delivery and Operations." **Kaiser** must develop a mechanism to ensure grievance resolution language is at or near the sixth grade reading level to the extent possible.

Although member-facing timelines were listed accurately, in two NABD letters reviewed, this time frame was inaccurately depicted as a 30-calendar day filing time frame. **Kaiser** must develop a mechanism to ensure that accurate timelines for requesting an appeal are included in member communications.

Appeal record reviews demonstrated that, in two cases, **Kaiser** prematurely closed appeal cases due to not receiving a written appeal. Notably, the cases were closed within a day or a few days after receiving the oral appeal, indicating that **Kaiser** did not utilize the full 10-business day time frame or the 14-day extension available to pursue the written appeal, which would have been in the member's best interest. However, due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, written appeals are no longer required and, therefore, there will be no required corrective actions related to the pursuit of a written appeal.

Although **Kaiser**'s policies and member information contained accurate information regarding appeal acknowledgement time frames, the record review contained two instances in which appeal acknowledgement letters were not sent within two working days. **Kaiser** must develop a mechanism to ensure that appeal acknowledgement letters are sent in accordance with timeliness standards.

As mentioned previously, two appeals cases were closed prematurely due to oral receipt and **Kaiser** not receiving a written request for the appeal. While **Kaiser** did adhere to the "earliest possible filing" date portion of this requirement, staff members did not attempt to pursue the appeal and, therefore, did not treat the oral appeal as an appeal. The actions of staff members were not in alignment with the intent of this regulation. Furthermore, during the virtual interview, staff members had conflicting statements regarding whether or not they would "wait" to receive additional documents. Although Medicaid and CHIP managed care regulations posted November 13, 2020, no longer require a written appeal, **Kaiser** must update internal procedures and associated training materials to ensure oral appeals are pursued as appeals.

Although **Kaiser**'s policies accurately described the process of denying an expedited appeal request and transferring to standard time frames, one appeal sample showed that the member communication incorrectly stated the standard resolution was 14 days instead of the 10-day time frame. Additionally, the record review sample containing the denial of the expedited appeal letter did not include the member's right to file a grievance if he or she disagreed with that decision. **Kaiser** must ensure that member communications related to the denial of an expedited resolution of an appeal accurately describe the applicable time frames. **Kaiser** must also inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited appeal request.

Within **Kaiser**'s documents, the details for continuation of benefits during an appeal did not clarify that, while the member has 10 days to request the continuation of benefits, the full 60 calendar days to request the appeal still applies. Also, the EOC incorrectly described the SFH continuation of benefits to take place 10 calendar days from the NABD or before the effective date of the termination. For an SFH, the request for continued benefits must occur 10 days after an appeal resolution not in favor of the member. Additionally, **Kaiser** did not clarify that the provider cannot request continuation of benefits on the member's behalf (due to the potential financial liability for the member). Lastly, the EOC also contained a confusing statement next to the criteria that the appeal is about a reduction, suspension, or termination of a previously approved service, which stated in parentheses: "unless you make a request for benefits to continue during your appeal." While HSAG understands that this is meant to convey to the member that services may be requested to continue, in this placement, it unintentionally confuses the criteria regarding continued benefits and should be removed. **Kaiser** must update documents related to continued benefits during an appeal and SFH to clearly describe applicable criteria and timelines.

Within the EOC document (page 31, Section 4), it was not clear that both the continuation of benefits and the SFH must be requested within the 10 days after the appeal is resolved not in the member's favor. **Kaiser** must update documents to clarify that the member must request both the continued benefits and SFH within 10 days after the appeal resolution is not in the member's favor. While updating this section, HSAG also recommends clarifying the terminology "denied appeal" to "appeal resolution not in favor of the member."

The provider manual included limited information regarding grievances and did not specifically state that the member may file a grievance at any time, who may file a grievance, or that **Kaiser** would provide assistance. The grievance section did not include key timeline information such as when acknowledgement letters were mailed or the extension timeline. Language within the "Adverse Organization Determination" section was difficult to understand. The document also stated, "the member may ask for an SFH at any time during the appeal"; however, the member may only request an SFH upon exhaustion or deemed exhaustion of the internal appeal process. The provider information did not clarify that a provider cannot request continued benefits or clarify that the continuation of benefits and SFH must both be requested within 10 days of the appeal resolution not in the member's favor. **Kaiser** must update the provider manual and any related documents to comprehensively and accurately inform providers about the grievance, appeal, SFH, and continuation of benefit rights, timelines, and procedures.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Kaiser's Ethics and Compliance Program was comprised of national, regional, and local compliance officers that worked in conjunction with other departments to prevent, detect, and respond to compliance risks. Key compliance responsibilities were divided amongst revenue, security, and health plan operations departments with the regional compliance officer reporting directly to the chief compliance officer and regional president.

Kaiser's compliance program was clearly supported by policies, procedures, and a description of other regular reports. During the webinar interviews, staff members described quarterly Executive Compliance Committees, Regional Compliance Committees, and annual compliance trainings to name just a few compliance activities. Both committees included key leadership for a diverse perspective and opportunity to provide feedback about trends.

Staff members reported that CY 2020 compliance activities focused on deploying key information in a centralized method to provide updates throughout the COVID-19 pandemic, with an emphasis on telehealth services. Other significant changes included an October 2020 compliance restructuring to align local offices with the national reporting structure. Planned upcoming changes included the recruiting for one open position within the program integrity compliance operations team. No major software changes were reported.

Kaiser emphasized the development of a "speak up" culture related to compliance efforts. This effort aimed to shift training techniques from traditional rote learning to focusing on what triggers negative behaviors and reinforcing staff member responsibilities related to program integrity. In addition, training techniques, such as "booster" trainings, were deployed a few weeks after the initial orientation training, which HSAG noted was an effective approach to increase staff member retention of the materials. The Compliance Training policy included general provisions for additional management-level trainings, and **Kaiser**'s compliance team reported participation in annual external trainings.

Provider participation evidence outlined a comprehensive system for recruiting, screening, and retaining providers. Documented procedures followed National Committee for Quality Assurance (NCQA) and Clinical Laboratory Improvement Amendments (CLIA) standards and described a monthly exclusion check process. Systems such as Change Healthcare and Medical Staff Office Web-based software (MSOW) were used to monitor and ensure contracts were active. **Kaiser** referenced network adequacy reports to make decisions about recruiting and retention efforts.

Summary of Findings Resulting in Opportunities for Improvement

While documents included a general statement, HSAG recommends expanding language within the provider manual and/or provider contracts that **Kaiser** does not restrict healthcare professionals from communicating with members or advocating on behalf of members about *self-administered treatment* or

expressing preferences about future treatment decisions as long as the provider is doing so while acting within lawful scope of his or her practice.

A contract example provided during the audit included a statement to address any moral or religious objections. Staff members verbally reported that if a member requested services that the provider did not participate in due to moral or religious beliefs, the provider would be responsible to refer members to other providers or to **Kaiser**'s member services team. HSAG recommends including language in the provider application, provider manual, and/or provider onboarding to clearly indicate that providers should notify **Kaiser** about any services to which they object. Similarly, instructions should be included in the EOC for a CHP+ member, parent, or guardian to contact customer service in these situations.

Although timelines for **Kaiser**'s compliance team to investigate and respond to a compliance report were clearly outlined (i.e., 24 hours for urgent, 10 business days for high importance, 21 calendar days for routine), provider and staff-facing documents lacked specific provisions for prompt referral (i.e., staff reporting timelines). The *Principles of Responsibility* document provided many details regarding methods of reporting but did not include details about timelines for reporting. HSAG recommends including more specific expectations and timelines for provider and staff member reporting compliance issues.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

Kaiser provided delegation agreements and evidence of monitoring for four delegates: MedImpact Healthcare Systems, Incorporated (MedImpact); University Physicians, Incorporated (UPI); Memorial Hospital (Memorial); and O'Neil Digital Solutions, LLC (Digital Solutions). Monitoring consisted of a variety of tasks including summary reports that were presented to internal committees, reports received from the delegates and reviewed by **Kaiser** staff members, and minutes from joint operating committees. **Kaiser** policies and procedures adequately articulated the intent to maintain ultimate responsibility for the delegated tasks, as did each delegation agreement HSAG reviewed.

Each of the four delegation agreements HSAG reviewed specified the activities to be delegated, the delegate's reporting responsibilities, the delegate's agreement to comply with all applicable laws and the terms of the agreement, and remedies available to **Kaiser** for insufficient performance of the delegated responsibilities.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **Kaiser** evaluate its subcontracts to determine if there are other subcontracts or agreements that need to be amended to include the required revisions, which were added as requirements as part of the May 2016 revisions to the Medicaid and CHIP managed care regulations.

Summary of Required Actions

While **Kaiser**'s policies and procedures accurately articulated each of the provisions required to be included in the delegation agreements, only one of the four agreements (Digital Solutions) provided for review included all required provisions. The MedImpact, UPI, and Memorial agreements included language that **Kaiser** is ultimately responsible to CMS for performance of the delegated activities; however, the agreements did not adequately address the right of the State, CMS, Health and Human Services (HHS), or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed. **Kaiser** must amend the delegation agreements with MedImpact, UPI, and Memorial to include the required provisions that address the right of the State, CMS, HHS, or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed. **Kaiser** must ensure that the provision indicates that the right exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, and must specifically address the right to audit and access documents and systems at any time if there is suspicion of fraud.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ grievances and CHP+ appeals 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) for each of grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ grievance records that occurred between January 1, 2020, and December 31, 2020, and all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard 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.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a 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 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

All required actions were related to coverage and authorization of services. **Kaiser** was required to complete 10 required actions, including:

- Ensure that reviewers consult with the requesting provider for medical services to obtain additional information when appropriate.
- Correct its policies and procedures to reflect the accurate time frames for making standard and expedited authorization decisions.
- 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; and submit a written policy and procedure addressing this requirement.
- Simplify the content and language in the CHP+ NABD to comply with sixth grade reading level requirements (to the degree possible).
- Update 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.
- 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.

- Develop and implement procedures to determine financial responsibility of the contractor for poststabilization care services that have not been pre-approved, including (four required actions):
  1. For services administered within one hour of a request to **Kaiser** for pre-approval of poststabilization care.
  2. Circumstances in which **Kaiser** does not respond to a request for pre-approval within one hour, **Kaiser** cannot be contacted, or **Kaiser** staff members and the treating physician cannot come to an agreement regarding the member's care.
  3. Application of the criteria for when financial responsibility ends.
  4. Ensuring that **Kaiser** does not charge the member more for poststabilization services delivered out of network than for services delivered in network.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in March 2020. HSAG and the Department reviewed and approved portions of the proposed plan and responded to **Kaiser**. **Kaiser** submitted initial documents as evidence of completion in July 2020. **Kaiser** resubmitted final CAP documents in October 2020.

Summary of Continued Required Actions

Kaiser successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	Kaiser developed a new CHP Website in 2020 and we are in the process of updating member materials for 2021 to direct members to the new site: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/ Here is the link to the current site where CHP documents are posted: kp.org/formsandpubs • In the upper right corner, click Choose your region and select Colorado - Denver/Boulder/Northern/Mountain areas • The Plan services and information page displays, click Coverage information Scroll down to Child Health Plan Plus (CHP+) Plan Documents	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While some of Kaiser's CHP+ member information materials were written in easy-to-read language, Flesch-Kincaid grade level testing showed results ranging from the ninth through eleventh grade. These documents included the EOC booklet, the initial pages of the formulary, the benefit denial letter, and the physician retirement letter.		
Required Actions: Kaiser must implement a process to regularly review documents and simplify language, where possible, to ensure materials are easily understood.		
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B1—6.3.1.15	#1. 40547-13580-POSTCA_9900-POSTCA-001 V2.pdf #2 562162091_21_CHP+_MonthlyNewMemberPostcardUpdate_v2.pdf Each month Kaiser mails new members a 'CHP New Member Postcard' (attached). This postcard directs members to important member materials online or by calling Member Services to request a printed copy: 562162091_21_CHP+_MonthlyNewMemberPostcardUpdate_v2 #3. cco_CHP_Plan_New_Member_Guidebook The 'CHP New Member Guide' explains how to access care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	#4. CHP-DEN(07-20) with CATLAR The 'CHP Evidence of Coverage' i.e. Member Handbook explains benefits and other details	
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4	#4. CHP-DEN(07-20) with CATLAR Definitions (Bookmarked: page 56 of 62): Appeal, Copayment, Emergency Medical Condition, Emergency Services, Grievances, Habilitation Services, Health Plan, Medical Necessary, Plan Physician, Plan Provider, Prior Authorization, Rehabilitation Services, Skilled Nursing Facility, Urgent Care Services Also Definitions throughout EOC: Out of Plan Provider (page 17 of 62) Health Insurance (page 18 of 62) Premium (page 18 of 62) Primary Care Provider, Specialty Care (page 20 of 62) Physician Services (page 23 of 62) Plan Facility (page 23 of 62) Outpatient Care (page 25 of 62) Hospital/Inpatient Care (page 26 of 62) Ambulance (page 27 of 62) Prescription Drugs (page 27 of 62) Outpatient pharmacy drugs (page 27 of 62) Durable Medical Equipment (page 30 of 62) Emergency Services (page 32 of 62) Home Health (page 34 of 62) Hospice Care (page 35 of 62) Exclusions (page 42 of 62)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)* CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	#3. cco_CHP_Plan_New_Member_Guidebook #4. CHP-DEN(07-20) with CATLAR #5. chp-provider-directory-co-en #6. cco_hmo_formulary.pdf #7. Metrs_medicaid_adverse decision_initial determination_appeal_0.20.docx #8. CHP+ State Fair Hearing Insert.pdf #9. NOA-CHP+Benefit Denial.pdf #10. NOA-CHP+ Med Necessity Denial.pdf Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. Review documents on CHP Website (includes Provider Directory, Plan Formulary, Evidence of Coverage, New Member Guide): https://charitablehealth.kaiserpermanente.org/colorado/member-resources/ Link to Spanish versions: https://charitablehealth.kaiserpermanente.org/colorado-espanol/recursos-del-chp-plus/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that	Review documents on CHP Website: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/ #1. 40547-13580-POSTCA_9900-POSTCA-001 V2.pdf Kaiser mails new members the 'EOC Postcard'(attached) that includes a postcard that can be mailed at no cost for members to request a copy	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	of the 'CHP Evidence of Coverage' #2. 562162091_21_CHP+_MonthlyNewMemberPostcardUpdate_v2 #11. 2020-08.28 Revised CHP+ Desktop Procedures – page 3	
Findings: Language regarding the five-business day response time frame for documents requested in paper form was included in the EOC, New Member Guide, and the new member postcard. While the majority of Kaiser's operational processes for annual member information updates and outreach were comprehensive, the requirement for the five-business day response for sending member information in paper form when requested was not included in Kaiser's desktop procedure or in the delegated vendor's distribution of materials agreement. Additionally, compliance with Section 508 guidelines varied. The WAVE Web Accessibility Evaluation Tool identified errors on webpages of the KP.org website, including the landing page for finding a region (i.e., Denver/Boulder) and the landing page to search for providers. HSAG found several accessibility errors in Kaiser's provider directory PDF, EOC, and formulary documents.		
Required Actions: Kaiser must revise internal procedures to ensure a five-business day response time for member information paper document requests (i.e., EOC). Kaiser must also develop a process for regular testing of PDF documents available to members to ensure these documents meet accessibility requirements, and also to ensure that all member-related website information complies with Section 508 specifications for accessibility (i.e., Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1.5	#6. cco_hmo_formulary.pdf Kaiser uses our Commercial HMO formulary for CHP members. Here is the link to the Formulary on CHP Website: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract: Exhibit B1—7.5, 14.1.3.3, 14.1.7.6	#3. cco_CHP_Plan_New_Member_Guidebook #4. CHP-DEN(07-20) with CATLAR #5. chp-provider-directory-co-en #6. cco_hmo_formulary.pdf Kaiser includes the 'Nondiscrimination Notice and Help in Your Language' at the end of all member materials Review documents on CHP Website: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)*	#3. cco_CHP_Plan_New_Member_Guidebook #4. CHP-DEN(07-20) with CATLAR #5. chp-provider-directory-co-en #6. cco_hmo_formulary.pdf Kaiser includes the 'Nondiscrimination Notice and Help in Your	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B1—14.1.3.5, 14.1.3.10.1.3	Language' at the end of all member materials Review documents on CHP Website: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/	
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1	#1. 40547-13580-POSTCA_9900-POSTCA-001 V2.pdf Kaiser mails new members the 'EOC Postcard'(attached) that includes a postcard that can be mailed at no cost for members to request a copy of the 'CHP Evidence of Coverage' #2. 562162091_21_CHP+_MonthlyNewMemberPostcardUpdate_v2 #11. 2020-08.28 Revised CHP+ Desktop Procedures – page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B1—6.7.2, 14.1.3.13.3	#4. CHP-DEN(07-20) with CATLAR, bookmarked page 17	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B1—7.12.2, 14.1.8.1	#12. Physician Notification Letter_Termination #13. Physician Notification Letter_Retire.Leave #14. Transition of Care Policy_FINAL (page 1 and 3) Kaiser provides members written notice when Physicians are terminated or retire	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract: Exhibit B1—14.1.3.6-7	#5. chp-provider-directory-co-en, Page 3 addresses provider cultural competency, physical disability, and language accessibility. The directory displays facilities first, then provider (by specialty). Kaiser reports languages other than English when spoken by a provider. It is important to note that all KP providers are asked to complete Diversity training during onboarding	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	The CHP Provider Directory can be downloaded and printed: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/ Link to accessibility statement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not	#4. CHP-DEN(07-20) with CATLAR Bookmarked: Schedule of Benefits (page 3-10) How to Access Your Services and Get Approval of Benefits - Section VII (page 20-25) Benefits H. Family Planning Services (page 33) Benefits E. Plan Facilities (page 23) General Policy Provisions C. Advanced Directives (page 53)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B1—14.1.3.10 14.1.3.13.3.7 Exhibit K—1.1.4.1–3, 1.1.14, 1.1.30 Amendment 3: Exhibit K—1.1.7		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member.	#4. CHP-DEN(07-20) with CATLAR Bookmarked: Member Rights and Responsibilities – Section XIII (page 55)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ix) CHP+ Contract: Exhibit B1—14.1.3.10, 14.1.1.2.1-6, 14.1.1.3 Exhibit K—1.1.2		
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)*	#4. CHP-DEN(07-20) with CATLAR Bookmarked: Appeals and External Review (page 46-50)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.10.1, 1.1.10.1.1, 1.1.10.2, 1.1.10.5	#4. CHP-DEN(07-20) with CATLAR Bookmarked: Benefits (What is Covered) Emergency Services and Urgent Care Services (page 32-33)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or	#4. CHP-DEN(07-20) with CATLAR Bookmarked: Schedule of Benefits (page 3-10) Nondiscrimination Notice (page 61) Protect Yourself from Fraud (page 18) Contact Us (page 11) Benefits C Ambulance (page 27) It's important to note that KP CHP benefits include the 'Minimum Essential Benefits' included in the State plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.3, 1.1.19		
19. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Informing members that grievances concerning noncompliance with the advance directive requirements may be filed with the State Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B1—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Exhibit K—1.1.24	#4. CHP-DEN(07-20) with CATLAR Bookmarked: General Policy Provisions (page 52-53)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract: Exhibit B1—14.1.3.10.1	#1. 40547-13580-POSTCA_9900-POSTCA-001 V2.pdf Kaiser mails new members the 'EOC Postcard'(attached) that includes a postcard that can be mailed at no cost for members to request a copy of the 'CHP Evidence of Coverage' #2. 562162091_21_CHP+_MonthlyNewMemberPostcardUpdate_v2 #11. 2020-08.28 Revised CHP+ Desktop Procedures – page 3 Procedures – page 3 #15. KP.org preferences.pdf KP.org Preferences screenshot that shows members can set up their contact preferences online through their KP.org account. Also, Member Services is available for general questions, benefit questions, help with printing member documents, informing members about interpretation services, etc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: None	#4. CHP-DEN(07-20) with CATLAR Bookmarked: General Policy Provisions, Section E (page 53)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	21	**Total Score**		=	19
				Total Score ÷ Total Applicable		=	90%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 59, Grievance System	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments,	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 56, CHP + An Adverse Benefit Determination (ABD)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
premiums, deductibles, coinsurance, or other). • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A		
Findings: Kaiser's definition for "adverse benefit determination" included all the required criteria within the grievance and appeal policy; however, the definition was incomplete in the member-facing materials. Specifically, it lacked the definition elements that an NABD includes "the failure to provide services in a timely manner, as defined by the State" and "the denial of a member's request to dispute a member financial liability (cost-		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
sharing, copayments, premiums, deductibles, coinsurance, or other).” Kaiser and HSAG agreed that a third portion of the definition criteria related to rural residents did not apply to Kaiser’s CHP+ regions at this time (i.e., Denver and Boulder metro areas). Additionally, within the provider manual the term “adverse organization determination” was used rather than “adverse benefit determination.”		
Required Actions: Kaiser must update member-facing information to include the complete federal and CHP+ definition of “adverse benefit determination.”		
3. The Contractor defines “appeal” as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 57, CHP+ Appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines “grievance” as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. A grievance includes a member’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 59, CHP+ Grievance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B1—14.1.4.1.1, 14.1.5.1	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 7, Right to File AND Page 62, Representative (Appointed/Authorized) #2. CHP+ 2020 EOC, Page 31, #3 Who may file your Appeal? #3. CHP+ Your Rights Attachment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 8, Intake And Page 3, Alternative Formats #2. CHP+ 2020 EOC, Page 35, B How to File a Grievance	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.6, 14.1.5.8 10 CCR 2505-10 8.209.5.C, 8.209.4.E	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 29, Decision/Committee Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: None 10 CCR 2505-10—8.209.5.C, 8.209.4.E	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 29, Section 6.5.5.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 8, Section 6.1.1 Acceptance and Facilitation of a case	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 10 CHP+ Filing Timeframes and Methods Table	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's policy accurately stated that a member may file a grievance at any time; however, a section of the policy contained limitations regarding how many times the member can file a grievance. Section 6.1.7 stated, "Members or their authorized representative, have the right to file a repeat grievance on an issue and/or request that was previously resolved. A repeat grievance is allowed anytime if a member is unhappy with their initial complaint resolution, after which the member is considered to have exhausted internal Plan options." While Kaiser included that a member may request an external review by the Department, this language appeared much later in the policy and the "repeat grievance" definition still inaccurately described grievance limitations.		
Required Actions: Kaiser must update policies and any related documents to clarify that CHP+ members may file a repeat grievance without restriction.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.5.5 10 CCR 2505-10 8.209.5.B	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 22, Standard Acknowledgement Timeframes and Methods Table	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 35, 6.7.1 Resolution AND Page 37 Resolution Timeframes and Methods Table AND Page 7 Section 5.15.1 CHP+ Readability	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Nine of the 10 grievance resolution letters HSAG reviewed were written in a language that would be easy for a member to understand. However, in sample grievance number two, the grievance resolution letter in its entirety was written at an eleventh grade reading level, and the specific grievance disposition was written at a thirteenth grade reading level, including terms such as "Sr Manager of Digital Delivery and Operations."		
Required Actions: Kaiser must develop a mechanism to ensure grievance resolution language is at or near the sixth grade reading level to the extent possible.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B1—14.1.5.11 10 CCR 2505-10 8.209.5.G	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 40 Resolution Requirements, Section 6.7.2.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 43, Section 6.7.2.9.3 CHP+	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 10, Section 6.1.2.3 CHP+ Filing Timeframes and Methods	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although Kaiser's policies and procedures and the EOC accurately depicted the timeline for members to file an appeal, in two NABD letters reviewed, this time frame was inaccurately depicted as a 30-calendar day filing time frame.		
Required Actions: Kaiser must develop a mechanism to ensure that accurate timelines for requesting an appeal are included in member communications.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.2, 14.1.4.1.8.2 10 CCR 2505 10 8.209.4.B	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 10, Section 6.1.2.3 CHP+ Filing Timeframes and Methods	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Scored
Findings: Appeal record reviews demonstrated that, in two cases, Kaiser prematurely closed appeal cases due to not receiving a written appeal. Notably, the cases were closed within a day or a few days after receiving the oral appeal, indicating that Kaiser did not utilize the full 10-business day time frame or the 14-day extension available to pursue the written appeal, which would have been in the member's best interest. However, due to revisions to the Medicaid and CHIP managed care regulations posted November 13, 2020, written appeals are no longer required and, therefore, there will be no required corrective actions related to the pursuit of a written appeal.		
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 22, Section 6.3.1.2 CHP+ Standard Acknowledgement Timeframes and Methods	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although Kaiser's policies and member information contained accurate information regarding appeal acknowledgement time frames, the record review contained two instances in which appeal acknowledgement letters were not sent within two working days.		
Required Actions: Kaiser must develop a mechanism to ensure that appeal acknowledgement letters are sent in accordance with timeliness standards.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 13, Section 6.1.4 Contact Dates & Times AND Page 10, Section 6.1.2.3 CHP+ Filing Timeframes and Methods AND Page 13 Section 6.1.3 Authorized Representation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: As mentioned previously, two appeals cases were closed prematurely due to oral receipt and Kaiser not receiving a written request for the appeal. While Kaiser did adhere to the "earliest possible filing" date portion of this requirement, staff members did not attempt to pursue the appeal and, therefore, did not treat the oral appeal as an appeal. The actions of staff members were not in alignment with the intent of this regulation. Furthermore, during the virtual interview, staff members had conflicting statements regarding whether or not they would "wait" to receive additional documents.		
Required Actions: Although Medicaid and CHIP managed care regulations posted November 13, 2020, no longer require a written appeal, Kaiser must update internal procedures and associated training materials to ensure oral appeals are pursued as appeals.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.2-3 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 26, Section 6.3.3.3 CHP+: For all Appeals, the opportunity to present testimony AND Page 40, Section 6.7.2.4 AND Page 28, Section 6.4.10 New Evidence during an appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 19, Expedited Criteria, Section 6.2.2.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
resolution or supports a member's appeal. *42 CFR 438.410(a–b)* CHP+ Contract: Exhibit B1—14.1.4.1.8.1, 14.1.4.1.8.5 10 CCR 2505-10 8.209.4.Q-R		
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 13, Section 6.1.6 Cases not meeting Expedited Review AND Page 14 Section 6.1.6.2 AND Page 15 Section 6.1.6.4 – CHP+ Appeal notice within 2 calendar days	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although Kaiser's policies accurately described the process of denying an expedited appeal request and transferring to standard time frames, one appeal sample showed that the member communication incorrectly stated the standard resolution was 14 days instead of the 10-day time frame. Additionally, the record review sample containing the denial of expedited appeal letter did not include the member's right to file a grievance if he or she disagreed with that decision.		
Required Actions: Kaiser must ensure that member communications related to the denial of an expedited resolution of an appeal accurately describe the applicable time frames. Kaiser must also inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited appeal request.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 35, Section 6.7.1 Resolution Timeframes AND Page 37, Section 6.7.1.3 CHP+ Resolution Timeframes and Methods AND Page 7, Section 5.15.1 CHP+ Readability	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 37, Section 6.7.1.3 CHP+ Resolution Timeframes and Methods	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.4.1, 14.1.4.1.8.4.3 10 CCR 2505-10 8.209.4.K, 8.209.5.E	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Pages 30-33, Extensions (Grievance, Initial Determinations & Appeals), Section 6.6.1.2, Page 31 Section 6.6.2.1 and Page 33, Section 6.6.3.1 Appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 31, Section 6.6.2.1.2.1 AND Page 31, Section 6.6.2.1.2.2 within 2 calendar days AND Page 31, Section 6.6.2.1.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B1—14.1.4.1.7 10 CCR 2505-10 8.209.4.M	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 40, Section 6.7.2 Resolution Requirements AND Page 43, Section 6.7.2.9.3.2 The right to request State Fair Hearing AND Page 20, Section 6.2.4.2 Requests to continue ongoing course of previously approved treatment…. #3. CHP+ Your Rights Attachment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 5, Section 5.9.2 State Fair Hearing AND Deemed Exhaustion #2. CHP+ Evidence of Coverage (EOC), Page 33, Section 7 What happens with an appeal, Letter f	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.10.3	#2. CHP+ Evidence of Coverage (EOC), Page 33, Section B. External Review, 1.a & b	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if:	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 20, Section 6.2.4.2 Requests to continue ongoing course of previously approved treatment…. #2. CHP+ Evidence of Coverage (EOC), Page 31, Section 4 How you can continue receiving services when you appeal AND Page 34, Section B External Review 1.b If you want to have an action reviewed….	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		
Findings: Within Kaiser's documents, the details for continuation of benefits during an appeal did not clarify that, while the member has 10 days to request the continuation of benefits, the full 60 calendar days to request the appeal still applies. Also, EOC incorrectly described the SFH continuation of benefits to take place 10 calendar days from the NABD or before the effective date of the termination. For an SFH, the request for continued benefits must occur 10 days after an appeal resolution not in favor of the member. Additionally, Kaiser did not clarify that the provider cannot request the continuation of benefits on the member's behalf (due to the potential financial liability for the member). Lastly, the EOC also contained a confusing statement next to the criteria that the appeal is about a reduction, suspension, or termination of a previously approved service which stated in parentheses: "unless you make a request for benefits to continue during your appeal." While HSAG understands that this is meant to convey to the member that services may be requested to continue, in this placement, it unintentionally confuses the criteria regarding continued benefits and should be removed.		
Required Actions: Kaiser must update documents related to continued benefits during an appeal and SFH to clearly describe applicable criteria and timelines.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	#2, CHP+ Evidence of Coverage (EOC), Page 31, Section 4 How you can continue receiving services when you appeal a – c	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Within the EOC document (page 31, Section 4), it was not clear that both the continuation of benefits and the SFH must be requested within the 10 days after the appeal is resolved not in the member's favor.		
Required Actions: Kaiser must update documents to clarify that the member must request both the continued benefits and SFH within 10 days after the appeal resolution is not in the member's favor. While updating this section, HSAG also recommends clarifying the terminology "denied appeal" to "appeal resolution not in favor of the member."		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	#2. CHP+ Evidence of Coverage (EOC), Page 31, Section 4 How you can continue receiving services when you appeal, C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424* CHP+ Contract: Exhibit B1—14.1.4.1.9.4–5 10 CCR 2505-10 8.209.4.W-X	#2. CHP+ Evidence of Coverage (EOC), Page 34, Section B External Review, 1.e	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date was received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	#1. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 6, Section 5.12 File Retention AND Page 5, Section 5.10 Documentation #4. KP CHP Quarterly Report Fiscal Q4 Apr-Jun 2020 It is evidenced by the Quarterly reporting that the Plan submits to the Dept on a routine basis the following: Volumes - Quarterly report to capture grievance acknowledgments and resolution timeframes including volumes measured in 6 different categories: Access and Availability, Clinical Care, Customer Service, Financial/Billing, Rights/Legal, Enrollment/Disenrollment/Eligibility and Benefits Package.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)*	#5. 2019 Provider Manual – Member Rights and Responsibilities - Page 13 & 18, Section 7.3 Member Complaint & Grievance Appeal process	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		
Findings: The provider manual included limited information regarding grievances and did not specifically state that the member may file a grievance at any time, who may file a grievance, or that Kaiser would provide assistance. The grievance section did not include key timeline information such as when acknowledgement letters were mailed or the extension timeline. Language within the "Adverse Organization Determination" section was difficult to understand. The document also stated, "the member may ask for an SFH at any time during the appeal"; however, the member may only request an SFH upon exhaustion or deemed exhaustion of the internal appeal process. The provider information did not clarify that a provider cannot request continued benefits or clarify that the continuation of benefits and SFH must both be requested within 10 days of the appeal resolution not in the member's favor.		
Required Actions: Kaiser must update the provider manual and any related documents to comprehensively and accurately inform providers about the grievance, appeal, SFH, and continuation of benefit rights, timelines, and procedures.		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	10	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Scored	=	1	X	NS	=	NS
Total Applicable		=	33	**Total Score**		=	23
				Total Score ÷ Total Applicable		=	70%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B1—14.2.1.1	#1. CPMG Physician Selection Process #2. Provider Recruitment Retention Programs #3. Practitioner Credentialing P&P 5434-03 #4. Practitioner Recredentialing P&P 5434-04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* CHP+ Contract: Exhibit B1—14.2.1.3, 14.2.1.5	#3. Practitioner Credentialing P&P 5434-03 #4. Practitioner Recredentialing P&P 5434-04 #32. CAP & CLIA Accreditation #33. 7202-03 Facility Credentialing Kaiser Foundation Health Plan is NCQA accredited. These policies demonstrate our methods of credentialing and recredentialing participating providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B1—14.2.1.1.2.1—2	#5. KPCO Provider Manual Section 9_Compliance #31. Policy 5434-09 Nondiscrimination Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* CHP+ Contract: Exhibit B1—14.2.1.1.2.4, 14.2.1.1.5	#7. Interested Provider Process This is the workflow for contractors that are declined #8. Provider Participation This is a sample of the letter sent to providers #30. 20_10_13PP (No. 6103-7_NDPCPEC Process_Final.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B1—10.1	#10. Provider Contract Template #3. Practitioner Credentialing P&P 5434-03	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B1—14.2.1.6, 19.1.1	#10. Provider Contract Template #12. NATL.NCO.012, bookmarks 1, 2 & 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B1—19.1.1 and 19.1.2	#10. Provider Contract Template, bookmark #1 & 2 #5. KPCO Provider Manual Section 9_Compliance, bookmark 1 & 2 #12. NATL.NCO.012-bookmarks, 1, 2, 3 & 4 #15. KP Principles of Responsibility, bookmark 3, Section 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	#10. Provider Contract Template, bookmark 2 section 2.9.1 #11. Provider Manual Section 7 Member Rights, bookmark 1 section 7.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B1—10.4.3		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B1—14.1.3.13.3.7 Amendment 3: Exhibit K—1.1.7	#13. 2020 KP Annual Covered Services report Response: Kaiser Permanente is not a faith-based organization and does not deny services based on moral/religious grounds. Kaiser Foundation Health Plan of Colorado covers all services authorized by the contract. #6. CHP-DEN(07-20) with CATLAR Bookmarked: Schedule of Benefits (page 9)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and	#14. Ethics and Compliance Program Description This document provides information on Kaiser Permanente Health Plan of Colorado's compliance program, the structure of the compliance organization, information related to auditing and monitoring processes, prevention of fraud waste and abuse, and reporting structures.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5	#17. Compliance Training Policy NATLHR.012 Compliance Training is done upon employment and annually for Kaiser Permanente. The content in the attached training was used for both new hires and annual refresher training. The Compliance training is online for Kaiser Permanente Employees on KP Learn. This training requires attestation on the Principals of Responsibility. #15. KP Principles of Responsibility, bookmark 2 #34. Exhibit D – Fraud Plan 08-2020	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	#14. Ethics and Compliance Program Description #34. Exhibit D – Fraud Plan 08-2020 (Exhibit D from Ethics & Compliance Program Description) This entire document addresses policies, procedures for Fraud, Waste and Abuse #15. KP Principles of Responsibility, bookmark 2, 3 & 4 #16. KP NATL.NCO.003 Nonretaliation #17. Compliance Training Policy NATLHR.012 Compliance Training is done upon employment and annually for Kaiser Permanente. The content in the attached training was used for both new hires and annual refresher training. The Compliance training is online for Kaiser Permanente Employees on KP Learn. #10. Provider Contract Template, bookmark 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	#14. Ethics and Compliance Program Description #18. CO CHP Monthly Membership Report, bullet 2 #21. Internal Reporting of Overpayments, Self-Disclosure, and Repayment for Federal Health Program and ACA Funds, bullet 1 #22. Child Health Plan Plus – Alternate Reconciliation Process #23. Process for Monthly MCO Audit #12. NATL.NCO.012, bullet 3 #29. CHP ARP July 2020.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7		
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)* CHP+ Contract: None	#5. KPCO Provider Manual Section 9_Compliance, bookmark 4 #23. Process for Monthly MCO Audit	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified	#19. CHP Plus Discrepancy Invoice_Template (this is an example of the discrepancy report we submit to the State) #21. Internal Reporting of Overpayments, Self-Disclosure, and Repayment for Federal Health Program and ACA Funds, bullet 1 #22. Child Health Plan Plus – Alternate Reconciliation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
in the contract. *42 CFR 438.608(c)* CHP+ Contract: Exhibit B1—19.4.1, 19.4.4	Process #24. Ownership and Control Disclosure Form KPCO-	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: Exhibit B1—16.3.4.1.6	#25. KPCO Provider Manual Section 5 Billing and Payment, claims adjustment, bookmark 1 & 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	#10. Provider Contract Template, Member Hold Harmless, bookmark 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.106 CHP+ Contract Amendment 3: Exhibit B1—16.4.1		

Results for Standard VII—Provider Participation and Program Integrity							
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%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	#1. Delegation Oversight Policy 2020, Bookmark 1 #2. Letter of Agreement for Delegated Entity Services-2017.pdf, Exhibit B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3	#1. Delegation Oversight Policy 2020, Bookmark 2 & 3 #2. Letter of Agreement for Delegated Entity Services-2017.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	#1. Delegation Oversight Policy 2020, Bookmark #4 #2 Letter of Agreement for Delegated Entity Services, Bookmark #	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3	#1. Delegation Oversight Policy 2020, Bookmark 5 #2. Letter of Agreement for Delegated Entity Services-2017.pdf	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: While Kaiser's policies and procedures accurately articulated each of the provisions required to be included in the delegation agreements, only one of the four agreements (Digital Solutions) provided for review included all required provisions. The MedImpact, UPI, and Memorial agreements included language that Kaiser is ultimately responsible to CMS for performance of the delegated activities; however, the agreements did not adequately address the right of the State, CMS, HHS, or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed.		
Required Actions: Kaiser must amend the delegation agreements with MedImpact, UPI, and Memorial to include the required provisions that address the right of the State, CMS, HHS, or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed. Kaiser must ensure that the provision indicates that the right exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, and must specifically address the right to audit and access documents and systems at any time if there is suspicion of fraud.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
				Total Score ÷ Total Applicable		=	75%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Kaiser Permanente

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	November 17–18, 2020
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Rashida Tobar, Tina Santos, Nikki Fitt, Amanda Greenland, and Daisy Strickland

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/15/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	01/17/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: A letter sent on 01/16/20 denied the expedited request but did not include the right to file a grievance if the member disagreed.											
2	****	02/10/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/21/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: Acknowledgement letter dated 02/14/20.											
3	****	02/29/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	03/09/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
4	****	03/19/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	03/24/20	N/A	N/A	N/A
Comments: Acknowledgement letter not sent within two working days. The appeal was closed on 03/24/20 due to the appeal not being received in writing; no resolution letter was sent. The parent did follow-up at a later date with a written appeal and the original denial was overturned.											
5	****	06/01/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	06/2/20	N/A	N/A	N/A
Comments: The appeal was closed within one day of receipt of the appeal due to the appeal not being received in writing; no resolution letter was sent. Additional documentation was submitted at a later date and the original denial was upheld.											
6	****	06/15/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	06/22/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
7	****	07/01/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/15/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
8	****	08/18/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/31/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Kaiser Permanente

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
9	****	08/27/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/09/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**8**	**9**	**9**				**7**	**7**	**7**
Column Subtotal of Compliant (Met) Elements			**6**	**9**	**9**				**7**	**7**	**7**
Percent Compliant (Divide Met by Applicable)			**75%**	**100%**	**100%**				**100%**	**100%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**47**
Total Compliant (Met) Elements	**45**
Total Percent Compliant	**96%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Kaiser Permanente

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	November 17–18, 2020
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Rashida Tobar, Tina Santos, Nikki Fitt, Amanda Greenland, and Daisy Strickland

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/09/20	M ☒ N ☐ N/A ☐	01/29/20	14	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
2	****	01/16/20	M ☒ N ☐ N/A ☐	01/30/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐
Comments: Language in resolution letter tested at Flesch-Kincaid grade level 11.8 and included language that would not be easy for a member, parent, or guardian to understand.										
3	****	02/05/20	M ☒ N ☐ N/A ☐	02/26/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
4	****	02/08/20	M ☒ N ☐ N/A ☐	02/26/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
5	****	03/17/20	M ☒ N ☐ N/A ☐	04/04/20	14	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
6	****	03/19/20	M ☒ N ☐ N/A ☐	04/04/20	12	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
7	****	05/07/20	M ☒ N ☐ N/A ☐	05/22/20	11	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
8	****	06/24/20	M ☒ N ☐ N/A ☐	06/30/20	4	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
9	****	07/20/20	M ☒ N ☐ N/A ☐	07/25/20	5	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Kaiser Permanente

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
10	****	08/18/20	M ☒ N ☐ N/A ☐	09/09/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**8**	**6**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**10**			**10**	**8**	**6**	**10**	**9**
Percent Compliant (Divide Met by Applicable)			**100%**			**100%**	**100%**	**100%**	**100%**	**90%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**54**
Total Compliant (Met) Elements	**53**
Total Percent Compliant	**98%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **Kaiser**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager II
Erica Arnold-Miller	Project Manager II
Kaiser Participants	**Title**
Amanda Greenland	Manager, Customer Experience Operations
Anja Lopez	Program Manager
Annika Brugman	Senior Regulatory Consultant
Carlos Madrid	Senior Manager
Cathy Johnson	Regulatory Consultant
Chaise Quintal	Quality Review Coordinator
Chea Sanchez	Credentialing Supervisor
Cindy Freeman	Credentialing Program Coordinator
Daisy Strickland	Regulatory Consultant III
Deanna Thompson	Contract & Policy Analyst
Deborah Gosling	Communications Manager
Elizabeth Chapman	Consulting Project Manager
Janine Vincent	Compliance Consultant
Jeannie Hoover	Director, Health Plan Compliance
Jo Anne Doherty	Senior Consultant
Kathy Westcoat	Senior Director
Kim Cook	Accreditation Specialist
Kirsten Swart	Compliance Consultant II
Lauren Galpin	Medical Director, Medicaid
Liz Bradley	Project Manager
Michelle Collins	Membership Liaison III
Nikki Fitt	Manager, Customer Experience Operations
Rashida Tobar	Regulatory Consultant
Renae Pemberton	Senior Director, Provider Contracting

Kaiser Participants	Title
Rhonda Meili	Manager, Network Provider Relations
Robin Dam	Compliance Auditor
Robin Einhorn	Manager, Network Development
Shamica Brown	Business Process Consultant
Stephanie Gelsey	Member Communication Consultant
Tina Santos	Senior Consultant
Department Observers	**Title**
Amy Ryan	CHP+ Contract & Program Administrator
Elizabeth Mattes	CHP+ Program Coordinator
Jeff Jaskunas	CHP+ Program Manager
Russ Kennedy	Quality Program Manager

Appendix D. Corrective Action Plan Template for FY 2020–2021

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 SAFE 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 2020–2021 Corrective Action Plan for Kaiser

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	While some of Kaiser's CHP+ member information materials were written in easy-to-read language, Flesch-Kincaid grade level testing showed results ranging from the ninth through eleventh grade. These documents included the EOC booklet, the initial pages of the formulary, the benefit denial letter, and the physician retirement letter.	Kaiser must implement a process to regularly review documents and simplify language, where possible, to ensure materials are easily understood.
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	Language regarding the five-business day response time frame for documents requested in paper form was included in the EOC, New Member Guide, and the new member postcard. While the majority of Kaiser's operational processes for annual member information updates and outreach were comprehensive, the requirement for the five-business day response for sending member information in paper form when requested was not included in Kaiser's desktop procedure or in the delegated vendor's distribution of materials agreement. Additionally, compliance with Section 508 guidelines varied. The WAVE Web Accessibility Evaluation Tool identified errors on webpages of the KP.org website, including the landing page for finding a region (i.e., Denver/Boulder) and the landing page to search for providers. HSAG found several accessibility errors in Kaiser's provider directory PDF, EOC, and formulary documents.	Kaiser must revise internal procedures to ensure a five-business day response time for member information paper document requests (i.e., EOC). Kaiser must also develop a process for regular testing of PDF documents available to members to ensure these documents meet accessibility requirements, and also to ensure that all member-related website information complies with Section 508 specifications for accessibility (i.e., Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain services	Kaiser's definition for "adverse benefit determination" included all the required criteria within the grievance and appeal policy; however, the definition was incomplete in the member-facing materials. Specifically, it lacked the definition elements that an NABD includes "the failure to provide services in a timely manner, as defined by the State" and "the denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other)." Kaiser and HSAG agreed that a third portion of the definition criteria related to rural residents did not apply to Kaiser's CHP+ regions at this time (i.e., Denver and Boulder metro areas). Additionally, within the provider manual the term "adverse organization determination" was used rather than "adverse benefit determination."	Kaiser must update member-facing information to include the complete federal and CHP+ definition of "adverse benefit determination."

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A		
Planned Interventions:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	Kaiser's policy accurately stated that a member may file a grievance at any time; however, a section of the policy contained limitations regarding how many times the member can file a grievance. Section 6.1.7 stated, "Members or their authorized representative, have the right to file a repeat grievance on an issue and/or request that was previously resolved. A repeat grievance is allowed anytime if a member is unhappy with their initial complaint resolution, after which the member is considered to have exhausted internal Plan options." While Kaiser included that a member may request an external review by the Department, this language appeared much later in the policy and the "repeat grievance" definition still inaccurately described grievance limitations.	Kaiser must update policies and any related documents to clarify that CHP+ members may file a repeat grievance without restriction.
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	Nine of the 10 grievance resolution letters HSAG reviewed were written in a language that would be easy for a member to understand. However, in sample grievance number two, the grievance resolution letter in its entirety was written at an eleventh grade reading level, and the specific grievance disposition was written at a thirteenth grade reading level, including terms such as "Sr Manager of Digital Delivery and Operations."	Kaiser must develop a mechanism to ensure grievance resolution language is at or near the sixth grade reading level to the extent possible.
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	Although Kaiser's policies and procedures and the EOC accurately depicted the timeline for members to file an appeal, in two NABD letters reviewed, this time frame was inaccurately depicted as a 30-calendar day filing time frame.	Kaiser must develop a mechanism to ensure that accurate timelines for requesting an appeal are included in member communications.
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	Although Kaiser's policies and member information contained accurate information regarding appeal acknowledgement time frames, the record review contained two instances in which appeal acknowledgement letters were not sent within two working days.	Kaiser must develop a mechanism to ensure that appeal acknowledgement letters are sent in accordance with timeliness standards.
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	As mentioned previously, two appeals cases were closed prematurely due to oral receipt and Kaiser not receiving a written request for the appeal. While Kaiser did adhere to the "earliest possible filing" date portion of this requirement, staff members did not attempt to pursue the appeal and, therefore, did not treat the oral appeal as an appeal. The actions of staff members were not in alignment with the intent of this regulation. Furthermore, during the virtual interview, staff members had conflicting statements regarding whether or not they would "wait" to receive additional documents.	Although Medicaid and CHIP managed care regulations posted November 13, 2020, no longer require a written appeal, Kaiser must update internal procedures and associated training materials to ensure oral appeals are pursued as appeals.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	Although Kaiser's policies accurately described the process of denying an expedited appeal request and transferring to standard time frames, one appeal sample showed that the member communication incorrectly stated the standard resolution was 14 days instead of the 10-day time frame. Additionally, the record review sample containing the denial of the expedited appeal letter did not include the member's right to file a grievance if he or she disagreed with that decision.	Kaiser must ensure that member communications related to the denial of an expedited resolution of an appeal accurately describe the applicable time frames. Kaiser must also inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited appeal request.
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be*	Within Kaiser's documents, the details for continuation of benefits during an appeal did not clarify that, while the member has 10 days to request the continuation of benefits, the full 60 calendar days to request the appeal still applies. Also, EOC incorrectly described the SFH continuation of benefits to take place 10 calendar days from the NABD or before the effective date of the termination. For an SFH, the request for continued benefits must occur 10 days after an appeal resolution not in favor of the member. Additionally, Kaiser did not clarify that the provider cannot request the continuation of benefits on the member's behalf (due to the potential financial liability for the member). Lastly, the EOC also contained a confusing statement next to the criteria that the appeal is about a reduction, suspension, or termination of a previously approved service which stated in parentheses: "unless you make a request for benefits to continue during your appeal." While HSAG understands that this is meant to convey to the member that services may be requested to continue, in this placement, it unintentionally confuses the criteria regarding continued benefits and should be removed.	Kaiser must update documents related to continued benefits during an appeal and SFH to clearly describe applicable criteria and timelines.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		

Standard VI—Grievance and Appeal Systems		
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:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U	Within the EOC document (page 31, Section 4), it was not clear that both the continuation of benefits and the SFH must be requested within the 10 days after the appeal is resolved not in the member's favor.	Kaiser must update documents to clarify that the member must request both the continued benefits and SFH within 10 days after the appeal resolution is not in the member's favor. While updating this section, HSAG also recommends clarifying the terminology "denied appeal" to "appeal resolution not in favor of the member."

Standard VI—Grievance and Appeal Systems		
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:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final	The provider manual included limited information regarding grievances and did not specifically state that the member may file a grievance at any time, who may file a grievance, or that Kaiser would provide assistance. The grievance section did not include key timeline information such as when acknowledgement letters were mailed or the extension timeline. Language within the "Adverse Organization Determination" section was difficult to understand. The document also stated, "the member may ask for an SFH at any time during the appeal"; however, the member may only request an SFH upon exhaustion or deemed exhaustion of the internal appeal process. The provider information did not clarify that a provider cannot request continued benefits or clarify that the continuation of benefits and SFH must both be requested within 10 days of the appeal resolution not in the member's favor.	Kaiser must update the provider manual and any related documents to comprehensively and accurately inform providers about the grievance, appeal, SFH, and continuation of benefit rights, timelines, and procedures.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B		
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 IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State,	While Kaiser's policies and procedures accurately articulated each of the provisions required to be included in the delegation agreements, only one of the four agreements (Digital Solutions) provided for review included all required provisions. The MedImpact, UPI, and Memorial agreements included language that Kaiser is ultimately responsible to CMS for performance of the delegated activities; however, the agreements did not adequately address the right of the State, CMS, HHS, or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed.	Kaiser must amend the delegation agreements with MedImpact, UPI, and Memorial to include the required provisions that address the right of the State, CMS, HHS, or their designees to audit and access any documents or electronic systems that pertain to any aspect of services and activities performed. Kaiser must ensure that the provision indicates that the right exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, and must specifically address the right to audit and access documents and systems at any time if there is suspicion of fraud.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3		
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:		

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 the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

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 Department 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, 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 health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site 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 site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review 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 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 member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	health plan five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct Health Plan Site Review**
	• During the site review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved 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 and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.