Fiscal Year 2021–2022 Site Review Report

for

Kaiser Permanente

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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. The updated Medicaid and Child Health Plan *Plus* (CHP+) managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. 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 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) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2021–2022 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: Sep 27, 2021.

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 Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	5	5	3	1	1	0	60%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	18	18	0	0	0	100%
Totals	**65**	**65**	**63**	**1**	**1**	**0**	**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 standards in the compliance monitoring tool.

Table 1-2 presents the scores for **Kaiser** for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	90	90	0	10	100%
Recredentialing	90	83	83	0	7	100%
Totals	**190**	**173**	**173**	**0**	**17**	**100%**

*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 III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

During the virtual review, **Kaiser** staff members described the Population Health Care Management program, a main focus of which in calendar year (CY) 2021 was working toward a proactive outreach approach through enhanced care coordination registries and a re-design of the referral system. The updated referral system aimed to simplify paperwork/forms, reduce barriers to care, and encourage a proactive outreach.

Kaiser's policies, procedures, and staff member interviews outlined a comprehensive approach to coordination of care for new members through the onboarding process conducted by the New Member Connect (NMC) team. The welcome letter, postcard, and member identification (ID) card also provided the member with key information about **Kaiser** and pointed the member to the member portal for more information. The NMC team followed detailed procedures to outreach new members and described conducting health screenings, scheduling with a primary care provider (PCP), referring to utilization management to bridge any existing care, and/or providing the member with a care management referral if the staff documented any additional needs or health care issues. Desktop procedures detailed specific staff members (i.e., registered nurse, social worker, or community specialist) who may be involved for each type of care management follow-up need.

Kaiser's electronic health record (EHR) system, EPIC, included a module, Compass Roads, that allowed member demographics, claims, and admission, discharge, and transfer (ADT) data feeds and care management details to be easily visible and accessible. The care management structure included four programs to address different levels of health care needs: complex, integrated, pediatric care coordination, and a social work program. Staff members described the Compass Roads dashboard capabilities, which included monitoring at the member level and monitoring at an aggregate program level to observe trends. **Kaiser** reported external support from various community agencies to screen members for social determinants of health (SDOH). **Kaiser** staff members and local agencies had access to THRIVE, an online database that houses information about hundreds of community organizations. The platform assists staff members, external entities, and members in locating and matching services and supports based on individualized need.

Management oversight of the Compass Roads system allowed for oversight of the care management enrollment process, which included an attempt to enroll the member within three days of a referral. The Compass Roads system allowed for staff members to enter and monitor tasks and view a dashboard for progress toward goals, including individualized care plans with regularly scheduled updates and reviews. Lastly, regardless of the member's status with care management, **Kaiser** developed and began deploying additional text message reminders to encourage pediatric well-visits.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

Kaiser maintains a provider manual, principles of responsibility, and policies that pertain to member rights, protections, and confidentiality. **Kaiser** delineates member rights and responsibilities internally through staff member trainings, electronic and paper formats of the provider manual via the kp.org portal, and annual email reminders and letters sent to members. During **Kaiser**'s interview, staff members mentioned that **Kaiser** has a policy library that houses all its policies, including those that apply to member rights, protections, and confidentiality. This policy library allows all employees access to **Kaiser** policies and notifies owners of each of the policies when there is a policy due for review.

Kaiser's Nondiscrimination in the Provision of Healthcare policy states its purpose to be compliant with any applicable federal, State, and local laws and regulations such as the Americans with Disabilities Act. **Kaiser** stated that it designates a Civil Rights Coordinator to facilitate compliance with internal policies and these laws. **Kaiser** submitted the job description for the newly hired Civil Rights Coordinator for the region. This role oversees and facilitates compliance with civil rights policies and the applicable federal and State laws. **Kaiser** also submitted a non-retaliation policy, an internal reporting ethics and compliance concerns policy, and an ethics and compliance program description that substantiates **Kaiser**'s compliance with these laws. **Kaiser** emphasized that these policies are not limited to an individual's membership status. **Kaiser** developed a "belong at KP" training that focuses on nondiscrimination. During the interview, **Kaiser**'s staff members discussed how the organization ensures that members are informed of their rights through posters in all provider offices as well as on the online member portal, in addition to the member handbook.

Kaiser submitted a robust HIPAA [Health Insurance Portability and Accountability Act of 1996] Authorization policy and a Privacy and Information Security policy that outlined key examples of when staff members needed to seek written permission to share personal health information. **Kaiser**'s policy also recognized the few exceptions to HIPAA authorization requirements. **Kaiser** presented a Remote Work Guide, which highlighted how staff must ensure privacy in remote and work from home settings. Additionally, **Kaiser** safeguards information through annual phishing tests for its workforce, including providers, and testing internal employees on HIPAA compliance to prevent external intruders or reduce the potential for any privacy scams. **Kaiser** also has a technical team that regularly assesses **Kaiser**'s electronic medical records system and email communication flow. Staff members report that **Kaiser** offers targeted compliance and ad hoc trainings to staff who frequently handle sensitive information.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no recommendations that did not lead to required actions for this standard.

Summary of Required Actions

The 2022 KPCO Provider Manual presented information about member rights and responsibilities that emphasized a member's right to willingly participate in their healthcare and communicate with their doctor about appropriate and effective care. **Kaiser**'s CHP+ member handbook also presented information on member rights and responsibilities. Although **Kaiser** submitted a variety of documents to show that the organization communicates with providers and members to uphold member rights, **Kaiser** did not submit an internal policy regarding member rights. **Kaiser** must develop a policy that includes all member rights specified in this standard.

Kaiser presented a variety of documents that addressed member rights. While these documents addressed the majority of the rights described in this standard, they did not include all required details regarding the rights to "receive information in accordance with information requirements (42 CFR 438.10)", "be free from any form of restraint or seclusion used as a means of discipline and convenience" (retaliation and coercion were present), or "request and receive a copy of their medical records" (the right to amend or correct records was present). **Kaiser** must revise internal policies to include all the required member rights. HSAG recommends reinstating the retired member rights policy or developing a comprehensive member rights policy inclusive of all the required member rights details.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

Kaiser submitted extensive credentialing policies, procedures, and well-organized records that aligned with National Committee for Quality Assurance (NCQA) requirements. Many of **Kaiser**'s credentialing files were delegated to University Physicians, Inc. (UPI) which used Med Advantage as the credentials verification organization (CVO). **Kaiser** staff members submitted evidence of annual monitoring for UPI. UPI maintained a malpractice liability policy that met the NCQA required threshold for coverage. Credentialing files processed by **Kaiser** contained primary source details and extensively detailed verification of work history. The LexisNexis Watchlist Report searched State and federal listings to ensure that the practitioner was in good standing.

Staff members described that from the time a practitioner submitted a clean application, **Kaiser** processing averaged 20 days to approval. In some cases, **Kaiser** used the provisional credentialing approach for 60 days and collected the minimum required documentation required by NCQA. A memo summarizing CY 2020 credentialing noted that there were no documented cases of applicants with clean files who were rejected in 2020. The annual memo served as a mechanism to review any practitioners who may be declined through the credentialing process to ensure no discrimination occurred during the

process. Practitioners were informed of their credentialing rights through their Council for Affordable Quality Healthcare (CAQH) application.

Machine learning internet-based programs monitored the online provider directory for data accuracy and any updates based on behind-the-scenes searches for State and federal lists. Additionally, on a quarterly basis, **Kaiser** outreached providers to confirm and update provider directory information as needed. The provider data management group described the process of receiving these updates, incorporating the information, and using a direct feed that pushed updates to the online provider directory. One approach that HSAG noted as a best practice was **Kaiser**'s effort to engage in an audit of currently contracted providers and place a random phone call to five offices to test the provider's knowledge of the provider's network participation with **Kaiser**.

If present in the electronic health record system, any internal complaints and quality of care concern trends were included in the credentialing packet. Staff members described how this information could be accessed and reviewed by the credentialing committee.

Kaiser staff members described a pre-delegate assessment process and reported new delegates in the last 12 months. **Kaiser** staff members maintained a timeline for tracking upcoming due dates for on-site visits. Staff members were available to conduct on-site visits if State visits were delayed due to coronavirus disease 2019 (COVID-19).

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

Kaiser submitted extensive documentation to support a comprehensive quality assessment and performance improvement (QAPI) program. Documents included a quality program description, work plan, and evaluation as the key "trilogy" set of documents that were reviewed and approved by senior leadership through an extensively structured set of workgroups and committees. Staff members described prioritized projects to include SDOH screenings, performance improvement projects (PIPs), and COVID-19 vaccination efforts to name a few. Extensive reports submitted demonstrated overutilization monitoring and underutilization efforts included monitoring gaps in care and a recently

launched text messaging reminder system, which outreached parents of members in age-based cohorts as a reminder to schedule well-visits.

Clinical practice guidelines stored in **Kaiser**'s clinical library were reviewed, developed, and approved in accordance with regulations, and updated on a regular basis as evidenced by the up-to-date samples. In addition to the provider-facing materials, **Kaiser** also maintained member-facing materials that effectively outlined care standards for members.

Kaiser's health information system integrated a platform named Common Membership and other timely data sources such as ADT notifications, which all feed into the EPIC system. The data warehouse also exported into Microsoft Business Intelligence dashboards, which provided what staff members described to be a usable medium of visualizing key trends. The claims processing workflow addressed how automated software identified any issues, such as data formatting which would be sent back to the provider to address, or larger issues such as extremely high-cost claims which required additional handling, review, and approval from claims staff members before the claim could be further processed in the system.

Lastly, member perception of satisfaction with access and quality of services was monitored through numerous avenues described by **Kaiser** in its quality program description. Efforts were further evidenced through other documents within the credentialing standard where **Kaiser** ensured organizational providers also deployed member satisfaction measures on a regular basis.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of 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+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines 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 credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all CHP+ credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. 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 VIII—Credentialing and Recredentialing. 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 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed 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.

Related to Standard VII—Provider Participation and Program Integrity, **Kaiser** had no required actions.

Related to Standard V— Member Information Requirements, **Kaiser** was required to:

- Implement a process to regularly review documents and simplify language, where possible, to ensure materials are easily understood.
- Ensure a five-business day response time for member information paper document requests.
- Develop a process for regular testing of Portable Document Format (PDF) documents available to members to ensure these documents meet accessibility requirements, and 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 of 1973 and World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines).

Related to Standard VI—Grievance and Appeal Systems, **Kaiser** was required to:

- Update member-facing information to include the complete CHP+ definition of "adverse benefit determination."
- Update policies and any related documents to clarify CHP+ members may file a repeat grievance without restriction.

- Develop a mechanism to ensure grievance resolution language is at or near the sixth-grade reading level to the extent possible.
- Ensure accurate timelines for requesting an appeal are included in member communications.
- Develop a mechanism to ensure appeal acknowledgement letters are sent in accordance with timeliness standards.
- Update internal procedures and associated training materials to ensure oral appeals are pursued as appeals.
- Ensure member communications related to the denial of an expediated resolution of an appeal accurately describe the applicable time frame. Additionally, inform the member of the right to file a grievance if the member disagrees with the decision to deny the expediated appeal request.
- Update documents related to continued benefits during an appeal and State fair hearing (SFH) to clearly describe applicable criteria and timeliness.
- Update documents to clarify that the member must request both the continued benefits and SFH within 10 days after an appeal resolution is not in the member's favor as well as clarifying the terminology "denied appeal" to "appeal resolution not in favor for the member."
- Update the provider manual and any related documents to comprehensively and accurately inform providers about the grievance, appeal, SFH, and continuation of benefits rights, timelines, and procedures.

Related to Standard IX—Subcontractual Relationships and Delegation, **Kaiser** was required to:

- Amend the delegation agreements with MedImpact, UPI, and Memorial to include all required language.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in March 2021. HSAG and the Department reviewed and approved with feedback the proposed plan and responded to **Kaiser**. **Kaiser** submitted initial documents as evidence of completion in July 2021. **Kaiser** resubmitted all final CAP documents in November 2021.

Summary of Continued Required Actions

Kaiser successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)*	The process and workflows for assuring coordination of care for all new CHP+ members is documented from the point a new member meets with our onboarding team through the appointed primary care provider and pharmacy. Documentation includes actions taken and policies used to guide the provision of necessary continuity of care services or referral to Pediatric Care Coordination to ensure there is no disruption in the provision of needed services. Please see the file 'PCC & CCM New Member Workflow' which documents this process from the initial point of contact with our onboarding team through the appointed primary care provider and orders and referrals to ensure continuity of care. The file 'Definitions 1508' documents the information to be collected from the member during onboarding. 'Authorization of Service Policy' documents our policy and process for the review of continuation of care for new CHP+ members. • KFHP_QualityProgramDescription_KPCO_2021 **page 14-19** (B1,2) • 2021 Pediatric Care Coordination Program Description, **page 3-4** (B1,2) • One-Sheet_PMIC_FINAL (B1,2) • Lippincott Procedures - Population Management and Integrated Care RN Adult Care Coordination Outreach (B1,2) • Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach (B1,2) • PCM Playbook - Narrative - FINAL - 8.31.21 (B1,2) • 2 month well visit smartset with kp.org pre visit questionnaire, **page 6** (B3) • Informed Consent **page 1 sections 1.0, 2.0** (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B-2—10.5.1, 10.5.2, 10.5.3.3	• Clinical Criteria for UM **page 1 sections 2.0, 5.0** (B4) • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 14 Continuity of Care** (B5), **page 32 Referrals** (B4) • Authorization of Service Policy 07.22.2021, **page 5-6 sections 5.7.6, 5.7.7** (B4,5) • PCC and CCM New Member Workflow (B5) • Definitions 1508 updated 2021 (B5) • Colorado Continuity of Care Guidelines and Handling (B5)	
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B-2—10.5.3.1	These documents include the welcome information provided when a member's ID card is generated, which indicates how to link to a PCP. The PCPs are informed that new members have been added to their panel based on individual panel reports. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 29 Primary Care Provider** • KFHP_QualityProgramDescription_KPCO_2021 **page 15 PMIC** • PC Continuity report • R3 CHP+ Postcard Proof • 659514217_21_CHP+_MonthlyNewMemberPostcard_ JulyUpdate_v2 • CB NM (ID Card)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-	These policies describe how KP coordinates care for members: • Authorization of Service Policy 07.22.2021, page 1 section 5.0 (B1), page 5 section 5.7.6 (B2) • Colorado Continuity of Care Guidelines and Handling (B1) • 2021 Pediatric Care Coordination Program Description, page 3-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—10.5.3.2.1, 10.5.3.2.1.1-2, 10.5.3.2.1.4	• Hosp Admission Auth and Review page 1 section 1.0 (B1) • Transitions of Care page 1 section 1.0 (B1) • KFHP_QualityProgramDescription_KPCO_2021 page 14-19 (B2,4) • KPCO_Provider_Manual_Section_3_Member_Eligibility_Benefits, page 17 section 3.5.11 (B3)	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B-2—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	KP's current onboarding process ensures that we attempt to contact newly enrolled CHP+ members multiple times within the first 90 days to complete a screening for mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. This screening (Definitions 1508-Final) is a part of the intake assessment documented in Health Connect. • DLP Outbound Calls (B1) • Definitions 1508 updated 2021, **page 1 and 2, questions 8, 9, 13, 14, 15, 16, and 17** (B2) • PCC and CCM New Member Workflow (B1,2) • Well Child age 9-10 Smartset (B2) • 2 month well visit smartset with kp.org pre visit questionnaire (B2) • One-Sheet_PMIC_FINAL (B3) • Lippincott Procedures - Population Management and Integrated Care RN Adult Care Coordination Outreach (B3) • Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• 2021 Pediatric Care Coordination Program Description, **page 3-4** (B3) • PCM Playbook - Narrative - FINAL - 8.31.21, **page 4 and 6** (B3)	
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B-2—10.4.1.3	Information is shared with other entities through our EMR and Affiliate link systems to alert of member's needs and prevent duplication of services. • KFHP_QualityProgramDescription_KPCO_2021 **page 14-19** • PCM Playbook - Narrative - FINAL - 8.31.21, **page 4-6** • 2021 Pediatric Care Coordination Program Description, **page 3-4** • KPCO_Provider_Manual_Section_6_Provider_Rights, **page 9 and 13** • PCC and CCM New Member Workflow • Definitions 1508 updated 2021 • One-Sheet_PMIC_FINAL • Lippincott Procedures - Population Management and Integrated Care RN Adult Care Coordination Outreach • Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B-2—10.5.6	These documents describe KP's processes to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record. • KFHP_QualityProgramDescription_KPCO_2021 **page 14-19** • KPCO_Provider_Manual_Section_6_Provider_Rights, **page 9 and 13** • KPCO_Provider_Manual_Section_8_Quality_Assurance_and_Improvement, **page 16 and 17 section 8.10**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B-2—10.5.5.9, 13.1.2	These documents describe KP's privacy policies for members. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 94 Privacy Practices** • 2022 KPCO Provider Manual_Section 7 Member Rights_CHP+ Updates, **page 5 and 6** • KPCO_Provider_Manual_Section_9_Compliance, **page 5 section 9.3** • HIPAA Authorization, **page 1 section 1.0, 2.0, 5.0** • Privacy and Information Security Policy, **page 1-5 sections 1.0, 2.0, 5.0** • PrinciplesOfResponsibility, **page 14**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B-2—10.5.9.1.1	The policies below describe how KP communicates and accommodates members with special health care needs. Members may also self-refer to some specialists as outlined in the EOC. • DLP Outbound Calls • Definitions 1508 updated 2021 • PCC and CCM New Member Workflow • PCM Playbook - Narrative - FINAL - 8.31.21, **page 8-13, 15** • 2021 Pediatric Care Coordination Program Description, **page 3-4** • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 14 Continuity of Care, Page 29 Primary Care Provider, Page 32 Referrals**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B-2—10.5.9.1.2-3	Treatment Plans for members with special health care needs who are described in the following documents. • KFHP_QualityProgramDescription_KPCO_2021 **page 14-19** • PCM Playbook - Narrative - FINAL - 8.31.21, **page 8-13, 15** • 2021 Pediatric Care Coordination Program Description, **page 3-4** • One-Sheet_PMIC_FINAL • Clinical Criteria for UM **page 1** (B2) • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 14 Continuity of Care, page 32 Referrals**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B-2—10.5.9.1.4	Self-referral to some specialists is available to members, and the time frame of the authorization is based on medical necessity as descripted under the Authorization of Services policy. • Authorization of Service Policy 07.22.2021, **1.0, 5.0** • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 14 Continuity of Care, page 32 Referrals**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	The CHP+ EOC specifies the rights provided to CHP+ members. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 83 Your Rights** • 2022 KPCO Provider Manual_Section 7 Member Rights_CHP+ Updates, **page 6 CHP+ Member Rights** • See Requirement #2-5 for more details	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: The 2022 KPCO Provider Manual presented information about member rights and responsibilities that emphasized a member's right to willingly participate in their healthcare and communicate with their doctor about appropriate and effective care. Kaiser's CHP+ member handbook also presented information on member rights and responsibilities. Although Kaiser submitted a variety of documents to show that the organization communicates with providers and members to uphold member rights, Kaiser did not submit an internal policy regarding member rights.		
Required Actions: Kaiser must develop a policy that includes all member rights specified in this standard.		
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B-2—15.10.9.2	The member rights are outlined in the Provider Manual which each KP affiliated provider receives. • 2022 KPCO Provider Manual_Section 7 Member Rights_CHP+ Updates, **page 6 CHP+ Member Rights** • KPCO_Provider_Manual_Section_9_Compliance, **page 4, 9.1** There is a section referring to the way in which we treat our members that exists in the Principles of Responsibility which each Kaiser Permanente employee receives upon their employment with Kaiser Permanente. • PrinciplesOfResponsibility, **page 7, 1.1 and page 31, 7.1.1** • Nondiscrimination in the Provision of Healthcare NATL.HPHO.007 (1202_2) **page 1 1.0, 2.0, 5.1, 5.4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's 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 their 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 their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).	The CHP+ EOC specifies the guaranteed rights provided to CHP+ members. Also, the policies below describe how KP ensures CHP Member Rights. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 83 Your Rights**, **Page 5 Other Languages and formats** (B1) • 2022 KPCO Provider Manual_Section 7 Member Rights_CHP+ Updates, **page 6 CHP+ Member Rights** • Nondiscrimination in the Provision of Healthcare NATL.HPHO.007 (1202_2) **page 1 section 1.0, 5.4** (B1) • PrinciplesOfResponsibility, o **page 14 and 30** (B2) • HIPAA Authorization, **page 1 section 1.0, 2.0** (B2) • Informed Consent, **page 1 section 1.0, 2.0, page 4 section 5.7.1** (B3, B4) • Internal Reporting of Ethic and Compliance Concerns, **page 2 section 5.5** (B5) • Amend PHI, **page 1 section 1.0, 2.0** (B6) • Authorization of Service Policy 07.22.2021 **page 1 section 1.0, 5.0** (B7)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.100(b)(2) and (3) Contract: Exhibit B-2—7.3.6.2-6		

Findings:

Kaiser presented a variety of documents that addressed member rights. The Evidence of Coverage (member handbook) for CHP+ members contained information that was aligned with the federal information requirements. The Nondiscrimination in the Provision of Healthcare policy described how Kaiser provided access to healthcare services and programs that are free from discrimination and protected by federal, State, and local law. Kaiser's Principles of Responsibility served as its code of conduct, which outlined the expectation for all employees to respect members' dignity and privacy and informed employees about almost all member rights, protections, and confidentiality. The HIPPA Authorization policy presents robust information on safeguarding protected health information (PHI) and protecting member privacy. Kaiser's Authorization of Service policy describes that members have timely access to medically necessary services. The Amend PHI policy described how members can request an amendment to health information and records, with internal procedures to inform employees about steps involved in this process and a timeline for how long it takes to accept or deny an amendment, but did not describe how a member can request and receive a copy of their medical records. These documents address the majority of the rights described in this standard; however, Kaiser's policies did not include all required details regarding the rights to "receive information in accordance with information requirements (42 CFR 438.10)", "be free from any form of restraint or seclusion used as a means of discipline and convenience" (retaliation and coercion were present), or "request and receive a copy of their medical records" (the right to amend or correct records was present).

Required Actions:

Kaiser must revise internal policies and procedures that pertain to member rights to include the rights to:

- *Receive information in accordance with information requirements (42 CFR 438.10).*
- *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 their medical records.*

HSAG recommends reinstating the retired member rights policy or developing a comprehensive member rights policy inclusive of all the required member rights details.

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B-2—7.3.6.3.7	The CHP+ EOC and the policies below specify that the member is free to exercise his/her rights without adverse effects. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 83 Your Rights** • 2022 KPCO Provider Manual_Section 7 Member Rights_CHP+ Updates, **page 6 CHP+ Member Rights** • Internal Reporting of Ethic and Compliance Concerns, **page 2 section 5.5** • PrinciplesOfResponsibility, **page 35 section 7.4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B-2—10.5.5.9, 13.1.2	The CHP+ EOC, Provider Manual and policies below include the member's right to be assured of privacy and confidentiality. • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 94 Privacy Practices** • 2022 KPCO Provider Manual_Section 7 **Member Rights_CHP+ Updates, page 6** • KPCO_Provider_Manual_Section_9_Compliance, **page 5 section 9.3** • HIPAA Authorization, **page 1 section 1.0, 2.0** • Privacy and Information Security Policy, **page 1 section 1.0, 2.0** • PrinciplesOfResponsibility, **page 14**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	3
			Total Score ÷ Total Applicable			=	60%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B-2—9.2.3.1	Note: These are NCQA health plan (HP) requirements available at the time of drafting this tool (07/2021). This document identifies our process for ensuring the evaluation and selection of providers that meet standards established by KP and all applicable regulatory and accreditation agencies, including NCQA. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021 – **Section 1-6** • Standard VIII_Requirement1_CR1_ NCQAFinal Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	This document identifies our policy and authority regarding credentialing and recredentialing; and lists the providers and heath care professionals covered by the policy. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **page 2 section 4.2**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc. *42 CFR 438.214(a)* NCQA CR1—Element A1		
2.B. The verification sources it uses. NCQA CR1—Element A2	This document identifies the verification sources used during the initial credentialing and recredentialing processes. See identified section. • 2021 Colorado Credentialing Procedure-Revised 4-2021, **p3-7, Sections 5.2 and 5.3**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	This document identifies the criteria used during the initial credentialing and recredentialing processes. See identified section. • 2021 Colorado Credentialing Procedure-Revised 4-2021, **p1, Section 3**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	This document describes the elements considered in the decision-making process during the initial credentialing and recredentialing processes. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p7-8, Section 5.9**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	This document describes the process for the files that meet established criteria for initial credentialing and recredentialing. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p6, Section 5.8.2**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	This document gives the current nondiscrimination policy statement for both credentialing and recredentialing. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p3, Section 5.3.** This document presents the results of the Credentialing Department's review of all providers approved or not approved during the previous year to verify there is no evidence of discrimination. The report is then reviewed by the Credentialing Committee. This report is prepared in Q1 of each year and reviews providers undergoing credential or recredentialing from the previous calendar year (reporting on activity in calendar year 2020). • Annual Non-discrimination Report for 2020	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	This document describes the policies related to employee access to the credentialing file, provider access to their own credentialing file, procedures for maintaining the confidentiality of the file and the provider's rights to notification of status. See indicated sections. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p4, Section 5.5**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	This document describes the policy for notifying the provider of the credentialing committee's decision for the initial credentialing and recredentialing processes. See indicated section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p8, Section 5.10**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	This document specifies the roles of the co-chairs of the Credentialing Committee. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p2, Section 4.1**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	This policy describes the agreement to maintain confidentiality of information obtained in the credentialing/recredentialing process. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p3-4, Section 5.4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	This policy outlines the process for ensuring that the CHP+ provider directory is consistent with credentialing data, and inclusive of education, training, certification, and specialty. • Practitioner and Provider Directory Policy and Procedure_Final_110118_NET5BG, **p5, Section 5.4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	This document contains a notification to providers of their right to review information. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p4, Section 5.5.2**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	This document contains a notification to providers of their right to review information. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p4, Section 5.5.3**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	This document contains a notification to providers of their right to review information. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p5, Section 5.6**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	This document describes the credentialing committee and their responsibilities. • C P Committee Charter 2020-Final, **p4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	These sections describe the process and committee responsibilities for reviewing practitioners not meeting thresholds during the initial credentialing recredentialing process. • C P Committee Charter 2020-Final, **p4** (B1) • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p7, Section 5.9** (B2) • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p6, Section 5.8.2** (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing.	This document details the verification process for credentialing and recredentialing within prescribed time limits. See identified sections. • 2021 Colorado Credentialing Procedure-Revised 4-2021 o Initial - **p3, Section 5.2.1** Recredentialing - **p5, Section 5.3.1** (B1) o Initial - **p3, Section 5.2.2** Recredentialing - **p5, Section 5.3.2** (B2) o Initial - **p4, Section 5.2.8** Recredentialing - **p6, Section 5.3.7** (B3) o Initial - **p4, Section 5.2.6** (B4) o Initial - **p3, Section 5.2.3** Recredentialing - **p5, Section 5.3.3** (B5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	This document describes verification of sanction activities for credentialing and recredentialing. See identified sections. • 2021 Colorado Credentialing Procedure-Revised 4-2021 o Initial - **p3, Section 5.2.4** Recredentialing - **p5, Section 5.3.4** (B1) o Initial - **p3, Section 5.2.4** Recredentialing - **p5, Section 5.3.4** (B2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	This is the application completed by practitioners for both initial credentialing and recredentialing. • 2021 Colorado Credentialing Procedure-Revised 4-2021 o p2, Section 5.1.6 (B1) o p2, Section 5.1.7 (B2) o p2, Section 5.1.8 (B3) o p2, Section 5.1.9 (B4) o p2, Section 5.1.10 (B5) o p2, Section 5.1.5 (B6) • 1CHCP 2017 app (Credentials Application) ▪ Supplemental B **#1-3 (page 26)** ▪ Supplemental A **#3 (page 25)** ▪ XII – Attestation Questions **p. 19-20** ▪ XII – Attestation Questions **p. 19-20** ▪ X. Professional Liability Insurance **p. 16-17** ▪ XIII. Attestation & Signature **p. 21**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	This document specifies the timing of recredentialing. See identified section. • 2021 Colorado Credentialing Oversight Policy-Revised 4-2021, **p7, Section 5.9.3**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	These policy and procedure documents describe collecting and reviewing all sanctions, limitations, complaints or adverse events impacting a provider's ability to practice, and the actions taken when any of the above are identified. • 2021 Colorado Ongoing Monitoring of Sanctions Procedure-Revised 4-2021 o p1, Section 5.1 (B1) o p1-2, Section 5.2 (B2) o p2, Section 5.3 (B3) o p2, Section 5.4 (B5) • 10. 7202-06 Regional Semi-Annual Complaints Review **page 1 sections 1.0, 2.0, 4.2** (B3) • Policy CO.DSQ.004 Formal Investigation, Corrective Action, Summary Suspension or Restriction, Administrative Suspension or Termination, and Reporting Policy, **page 1 sections 1.0, 2.0** (B4, B5) • 10. CO.DSQ.002_Peer Review and Evaluation of Practitioner Performance Policy (B5) • 10. LVAR Example	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor. • Making the appeal process known to practitioners.	These policy and procedure documents describe the range of actions taken and reporting practices for addressing quality. • Policy CO.DSQ.004 Formal Investigation, Corrective Action, Summary Suspension or Restriction, Administrative Suspension or Termination, and Reporting Policy, **page 3-9 sections 5.5, 5.6, 5.6.2** • 11. CO.DSQ.003_Colorado KFHP Fair Hearing Policy • KPCO_Provider_Manual_Section_8_Quality_Assurance_and_Improvement **page 16 section 8.8.1**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities. NCQA CR6—Element A	• KPCO_Provider_Manual_Section_7_Member_Rights, **page 13 section 7.3.1**	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	This document contains the initial and ongoing assessment policy for organizational providers. • Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service, **page 2-4 sections 6.2, 7.1, 7.2**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	This document contains the initial and ongoing assessment policy for organizational providers. • Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service, **page 2-5 sections 6.3, 7.3, 7.4, 7.7**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	This document contains the initial and ongoing assessment policy for organizational providers. • Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service, **page 3 section 6.4**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7-Elements B&C	This document contains the initial and ongoing assessment policy for organizational providers which is inclusive of the medical providers listed. • Policy 7202-03: Evaluation of Affiliated Organizational Provider Care and Service, **page 1 section 3.0**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health and/or physical health providers every 36 months. NCQA HP CR7-Elements D&E	This document contains documentation of assessment of contracted providers. • 14. CR7_Elements D & E_Medical Providers_2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	This document contains the 2015 delegation agreement with specified organizational provider which describes the required activities. • 2021 Colorado Delegated Credentialing Procedure-Revised 4-2021, **page 1-3 sections:** o 5.1 (B1) o 5.1.1 (B2) o 5.1.1.4 (B3) o 5.1.2 (B4) o 5.1.3 (B5) o 5.1.5.3 (B6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	Not Applicable, delegated agreement in effect for over 12 months	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	This document contains the results of the most recent audit of credentialing files. • 2021 Colorado Delegated Credentialing Procedure-Revised 4-2021, **page 1-2 sections**: o 5.1.1 (B1) o 5.1.1.1 (B2) o 5.1.1.4 (B3, B4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	This document contains the results of the most recent audit of credentialing files. • 2021 Colorado Delegated Credentialing Procedure-Revised 4-2021 page 3 section 5.1.5.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—14.1.1	Quality assessment and improvement tis the key function of the KP's Quality Program. The document below describes KP's quality program. • KFHP_QualityProgramDescription_KPCO_2021 o Page 3 Mission and Vision o Page 5 KPCO Quality Oversight Committee o Page 6 Annual Work Plan and Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators.	Quality assessment and improvement tis the key function of the KP's Quality Program. The documents below describe KP's quality workplan and evaluation. • KFHP_QualityProgramWorkplan_KPCO_2021, **Page 9** (B2, B4) • KFHP_QualityProgramEvaluation_KPCO_2020, **Page 8-9** (B3) The document below describes KP's CHP+ PIP: • CO2020-21_MCO_PIP-Val_Module 3_Submission Form_F1_V6-2_DepressionScreening-Follow-up 20210806, **page 2** (B2), **page 4** (B1) • 5. Quality Dashboards, **page 1** (B1, B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—14.2.1.1, 14.3		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—14.4	KP's Quality Program includes reporting and improving Performance Measures: • KFHP_QualityProgramDescription_KPCO_2021, **Page 6 Clinical Quality Oversight Program** • KFHP_QualityProgramWorkplan_KPCO_2021, **Page 9** • RE_ HEDIS Data Follow-up (evidence of submitting HEDIS data) (B1,2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—14.6	Mechanisms to detect over- and underutilization of services are in place and incorporated into KP's Quality Program and analyzed. These mechanisms include reports which shows over- and under- utilization. The Medicaid and CHP Quality Governance subcommittee evaluates utilization statistics and determines actions needed for identified problems. • KFHP_QualityProgramDescription_KPCO_2021, **Page 17 Utilization Management** • 1. MCP Quality Charter Feb 2021 • 2. 20210914AgendaMinutes Quality • 3. Text messaging for WELL CHILD REMINDERS 6.30.21 • 4. PAC Jun 2020-Jul2021 updates • 5. Quality Dashboards • SCREENSHOT CHP HIGH UTILIZATION CASE FINDING	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's QAPI Program includes mechanisms for identifying, investigating, analyzing, tracking, trending, and resolving any alleged quality of care concerns. Contract: Exhibit B-2—14.7.1-2	The policies below include how KP tracks, analyzes and resolves Quality of Care Concerns: • KFHP_QualityProgramDescription_KPCO_2021, **Page 10-11 Practitioner Participation and Credentialing** • X.5. CO.DSQ.002_Peer Review and Evaluation of Policy Number, **1.0, 2.0, 5** • X.5. CO.DSQ.002_Potential Quality of Care Concerns and Peer Review Events Procedure, **1.0, 4.0, 5** • X.5. CO.DSQ.002_Practitioner Performance Actions Procedure, **1.0, 4.0, 5** • X.5. CO.DSQ.002_Practitioner Quality Files Procedure, **1.0, 4.0, 5** • 7202-14_Complaints Referred to the Quality Department from Regional Nurse Screeners – Colorado, **1.0, 4.0**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—14.6.1	The Complex Case Management program has been developed based on NCQA standards and includes an initial assessment, criteria for follow-up, goals of care and monitoring through both a reporting workbench and a high-risk reporting workbench/panel reports. In addition, quarterly chart audit is in place within the QAPI program to assess the quality and appropriateness of care rendered to members with special healthcare needs. • KFHP_QualityProgramDescription_KPCO_2021, **Page 15 Population Health Management and Integrated Care** • 2021 Pediatric Care Coordination Program Description, **Page 4 Managing Members with SHCN and Complex Patients** • PCM Playbook - Narrative - FINAL - 8.31.21, **page 4, 6** • DCM Program Manual Revised 2021 • Care Management Report • ContinuumofCareOversightCommittee_CCOC_Charter_2021(FINAL) • Kaiser Permanente Colorado (KPCO) July CCOC report • Child to Adult Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—14.2.5	KP submits the annual Quality Improvement Workplan to the Health Care Policy & Financing CHP+ Contract Manager annually • KFHP_QualityProgramDescription_KPCO_2021 o Page 6 Annual Work Plan and Evaluation • KFHP_QualityProgramEvaluation_KPCO_2020 o Page 7-9 Quality Goals for CHP+ and Medicaid	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—10.5.8.2-4	These documents outline how guidelines are developed: • Clinical Guideline Policy and Procedure – 2018 **page 1-3 sections** o 4.1.2 (B1) o 2.0 (B2) o 4.1.1 (B3) o 4.2.1 (B4) • Clinical Criteria for UM, **page 1-3 sections 2.0, 5.1, 5.2**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B-2—10.5.8.1	Included below are examples of clinical guidelines: • Maternity Care — member guide to maternity care.(B1) • Pregnancy Toolkit — member guide to being pregnant. (B1) • Labor and Delivery Toolkit — member labor and delivery guide. (B1) • Postpartum Toolkit — member guide for the 6 weeks after delivery. (B1) • Women's Health Classes — member support from staff trained in breastfeeding baby. (B1) • ADHD Evaluation and Diagnosis Algorithm (B2) • Developmental Delay and Autism Referral Pathways (B2) • KM 03 Depression Documented Process Depression - Adult Guideline KPCO _ CO Clinical Library (B2) • Prevention Recommendations - Peds and Adolescent _ CO Clinical Library (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—10.5.8	The following document describes how the guidelines are disseminated. • KFHP_QualityProgramDescription_KPCO_2021, **Page 17 Utilization Management** • KPCO_Provider_Manual_Section_4_Utilization_Management, **page 5 section 4.2** • Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options o EOC **Page 35 Utilization Management section** • Clinical Library Policy and Procedure - 2018	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—10.5.8.5	The following document describes how utilization management guidelines are consistent with the guidelines. • KFHP_QualityProgramDescription_KPCO_2021, **Page 17 Utilization Management** • Authorization of Service Policy 07.22.2021, **page 1 section 5.0** • Clinical Criteria for UM • Clinical Guideline Policy and Procedure – 2018 • Clinical Library Policy and Procedure – 2018	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1	KP maintains a health information system that collects, analyzes, integrates and reports data. • KFHP_QualityProgramDescription_KPCO_2021 o Page 5 KPCO Quality Oversight Committee o Page 5 QOC Subcommittee Functions o Page 6 Annual Work Plan and Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	KP uses clinical information, membership demographics, and communications with members to integrate data for care management and reporting needs. • KFHP_QualityProgramDescription_KPCO_2021 o Page 11 Care Experience o Page 12 Care Experience Assessment • KP CHP Quarterly Report Fiscal Q4 Apr-Jun 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B-2—13.1.6.2	The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado. • Medicaid Encounter Data Submission Process Flow CO FINAL (2) • CO Response Report 092021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—13.1.5.1, 13.1.6.2	KP's claims processing is outlines in the following documents: • CO_CHP_HSAG_Item_13.1.5.1._POL05_Payments_to_Providers _PDF, **page 1 section 1.0** • CO_CHP_HSAG_Item_13.1.5. _Claims Processing System_PDF	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—13.6.1, 13.1.6.5.1	The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado. • Medicaid Encounter Data Submission Process Flow CO FINAL (B1) • CO Response Report 092021 (B2) • Encounter_Data_Monthly_Certification_Template_July 2021 (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards	The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado. • Medicaid Encounter Data Submission Process Flow CO FINAL (B1) • CO Response Report 092021 (B2) • Encounter_Data_Monthly_Certification_Template_July 2021 (B3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—13.1.6.2, 13.1.6.3.1, 13.1.6.4-5		
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. Contract: Exhibit B-2—14.5.1-2	KP provides monthly and quarterly reporting to the CHP+ Contract Manager at Health Care Policy and Financing which includes call center performance and appeals and grievance data. This data is monitored internally by KP prior to submission to the state. • 1. MCP Quality Charter Feb 2021 • 2. 20210914AgendaMinutes Quality (B2) • KP CHP Quarterly Report Fiscal Q4 Apr-Jun 2021 (B3,4) • Health Plan Ops Report SFQ4 April-June 2021 (B4) • Updated Dec 2020 - 2019 CHP+ CAHPS Summary_CAP v.asd (B1,5) • 2021 CAHPS Improvement Interventions - draft	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Kaiser Permanente

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	November 17, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Cindy Freeman

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 07/30/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 06/16/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 07/22/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 07/22/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: **** Credentialing Date: 01/22/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Kaiser Permanente

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: **** Credentialing Date: 04/15/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 04/22/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This file contained a malpractice claim that was filed in 2015 and later withdrawn by the patient.										
File #8 Provider ID: **** Credentialing Date: 09/16/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 07/22/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 01/28/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**5**	**10**	**5**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**5**	**10**	**5**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**90**
Total Number of Compliant Elements	**90**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see compliance tool for elements of complete application)
10. Verification time limits:

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Kaiser Permanente

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	November 16, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Cindy Freeman

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 04/30/21 Prior Credentialing or Recredentialing Date: 06/05/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 07/22/21 Prior Credentialing or Recredentialing Date: 07/26/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 02/25/21 Prior Credentialing or Recredentialing Date: 02/15/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: **** Current Recredentialing Date: 08/23/21 Prior Credentialing or Recredentialing Date: 03/21/19	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Kaiser Permanente

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: 04/30/21 Prior Credentialing or Recredentialing Date: 06/08/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: **** Current Recredentialing Date: 02/26/21 Prior Credentialing or Recredentialing Date: 04/27/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: **** Current Recredentialing Date: 04/19/21 Prior Credentialing or Recredentialing Date: 05/12/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 04/22/21 Prior Credentialing or Recredentialing Date: 04/01/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 04/19/21 Prior Credentialing or Recredentialing Date: 05/29/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 08/05/21 Prior Credentialing or Recredentialing Date: 08/24/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This practitioner's file included a report for unprofessional conduct, however, meeting minutes confirmed this was addressed during the 2018 credentialing cycle.									
Number of Applicable Elements	**10**	**7**	**6**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**7**	**6**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**83**
Total Number of Compliant Elements	**83**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

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

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2021–2022 site review of **Kaiser**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Eva Ogbon	Project Manager I
Lauren Gomez	Project Manager I
Crystal Brown	Project Coordinator III
Kaiser Participants	**Title**
Alain Martinez	Customer Experience Consultant
Amy Archer, Registered Nurse	Utilization Management Medical Audit Coordinator
Amy Bodette	Regional Director, Population Management and Integrated Care
Anja Lopez	Compliance Consultant, Kaiser Permanente Policies
Ashley Bush	Senior Business Analyst, National Management Encounter Reporting
Beth Champlin	Director, Credentialing
Carlos Madrid	Senior Manager, Medicaid and Charitable Programs
Casey Snow	Quality Review Coordinator—Accreditation, Regulatory and Licensure
Chaise Quintal	Quality Review Coordinator—Accreditation, Regulatory and Licensure
Chea Sanchez	Credentialing Supervisor
Christy Dupree	Senior Consultant, Quality Oversight Program
Cindy Freeman	Credentialing Compliance Coordinator
Cindy Huerta	Director, Utilization Management
Elizabeth Bradley	Project Manager, Provider Contracting
Erica Anderson	Regional Director, Maternity Care
Heidi Lorenz	Senior Director, Population Management and Integrated Care
Janine Foskett	Quality Oversight Program Specialist
Janine Vincent	Compliance Consultant, Claims
Kathy Westcoat	Senior Director, Medicaid and Charitable Programs
Kirsten Swart	Compliance Consultant
Laura L Jiron	Lead Customer Care Representative

Kaiser Participants	Title
Lauren Galpin MD	Medical Director, Medicaid and Charitable Programs
Liz Chapman	Medicaid and Charitable Programs Contract Manager
Mesha Sanford	Manager, National Management Encounter Reporting
Michelle Gattshall	Senior Program Manager, HEDIS
Michelle Roque	Quality Review Coordinator—Accreditation, Regulatory and Licensure
Mikala Gibbs	Project Manager, Network Adequacy and Provider Data
Paula Whittemore, RN	Medicaid and Charitable Programs Quality Resource Coordinator
Rachel Gomez	Program Manager, Population Management and Integrated Care
Renae Pemberton	Senior Director, Provider Contracting
Rhonda Rutherford	Regulatory Consultant, Member Services Call Center
Roxane England	Clinical Quality Consultant, Population Management and Integrated Care
Sean-Casey King	Director, Compliance
Department Observers	**Title**
Elizabeth Mattes	Project Coordinator
Jeff Helm	Program Design and Policy
Jeff Jaskunas	CHP+ Program Manager
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2021–2022

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

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

The CAP template follows.

Table D-2—FY 2021–2022 Corrective Action Plan for Kaiser

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Findings**	**Required Action**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	The 2022 KPCO Provider Manual presented information about member rights and responsibilities that emphasized a member's right to willingly participate in their healthcare and communicate with their doctor about appropriate and effective care. Kaiser's CHP+ member handbook also presented information on member rights and responsibilities. Although Kaiser submitted a variety of documents to show that the organization communicates with providers and members to uphold member rights, Kaiser did not submit an internal policy regarding member rights.	Kaiser must develop a policy that includes all member rights specified in this standard.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Findings**	**Required Action**
Documents for Final Submission:		
Date of Final Evidence:		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Findings**	**Required Action**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's 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 their 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 their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)*	Kaiser presented a variety of documents that addressed member rights. The Evidence of Coverage (member handbook) for CHP+ members contained information that was aligned with the federal information requirements. The Nondiscrimination in the Provision of Healthcare policy described how Kaiser provided access to healthcare services and programs that are free from discrimination and protected by federal, State, and local law. Kaiser's Principles of Responsibility served as its code of conduct, which outlined the expectation for all employees to respect members' dignity and privacy and informed employees about almost all member rights, protections, and confidentiality. The HIPPA Authorization policy presents robust information on safeguarding protected health information (PHI) and protecting member privacy. Kaiser's Authorization of Service policy describes that members have timely access to medically necessary services. The Amend PHI policy described how members can request an amendment to health information and records, with internal procedures to inform employees about steps involved in this process and a timeline for how long it takes to accept or deny an amendment, but did not describe how a member can request and receive a copy of their medical records. These documents address the majority of the	Kaiser must revise internal policies and procedures that pertain to member rights to include the rights to: • *Receive information in accordance with information requirements (42 CFR 438.10).* • *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 their medical records.* HSAG recommends reinstating the retired member rights policy or developing a comprehensive member rights policy inclusive of all the required member rights details.

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Findings**	**Required Action**
Contract: Exhibit B-2—7.3.6.2-6	rights described in this standard; however, Kaiser's policies did not include all required details regarding the rights to "receive information in accordance with information requirements (42 CFR 438.10)", "be free from any form of restraint or seclusion used as a means of discipline and convenience" (retaliation and coercion were present), or "request and receive a copy of their medical records" (the right to amend or correct records was present).	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

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 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 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 review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The health plans also submitted a list of all credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the 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 the review. HSAG notified the health plan five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the 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 review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and 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.