CHP+

Child Health Plan *Plus*

Fiscal Year 2022–2023 Compliance Review Report

for

Kaiser Permanente

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2022–2023 was January 1, 2022, through December 31, 2022. This report documents results of the FY 2022–2023 compliance 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 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, CHP+ MCO, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance 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)
I. Coverage and Authorization of Services	34	34	30	4	0	0	88%
II. Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI. Grievance and Appeal Systems	31	31	22	9	0	0	71%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**72**	**13**	**0**	**0**	**85%**

*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 denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	68	68	65	3	0	96%
Grievances	27	27	27	0	0	100%
Appeals	5	5	5	0	0	100%
Totals	**100**	**100**	**97**	**3**	**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 record review tools.

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

Kaiser submitted its *Utilization Management Program Description*, policies, procedures, inter-rater reliability validation results, and the member handbook that defined the implementation of requirements related to coverage and authorization of services. **Kaiser** used a robust group of providers, representing a wide variety of specialties, for medical necessity determinations. When requested services cannot be authorized by the utilization review clinicians or other licensed healthcare professionals, based on evidence-based medical necessity guidelines, the request, including all pertinent clinical information and criteria being used, receive a secondary review from a utilization management physician, board-certified specialty physician, psychiatrist, and occupational, physical and/or speech therapist, as needed. Once authorized, **Kaiser** reported that it does not reduce or suspend approved initial or continuing care or services.

Kaiser had well documented mechanisms in place to ensure consistent application of review criteria for authorization decisions. Staff members described an inter-rater reliability process that annually evaluated 5 percent or 50 cases from each type of healthcare professional (physician and non-physician) to assess for consistency in application of the criteria in decision making. Documentation received from **Kaiser** identified that all staff members met the inter-rater reliability threshold of 90 percent during the most current review process.

A review of case files identified that in the majority of cases, **Kaiser** met the standard and expedited time frames for providing members a written notice of decisions to deny a service authorization request. Staff members confirmed during the interview session that service requests were not authorized in the amount, duration, or scope that was less than requested. Staff members stated that they do not extend time frames for authorization decisions. **Kaiser** staff members reviewing the authorization requests were responsible for sending the notice of adverse benefit determination notice to ensure timeliness. **Kaiser**'s notice of adverse benefit determination notices included member rights and were written in an easily understood level and format, at or around the sixth-grade reading level.

Opportunities for Improvement and Recommendations

Although **Kaiser** addressed most federal and State requirements in its policies and procedures, not all requirements were included. **Kaiser** has an opportunity to update its policies, procedures, and the member handbook to ensure that all federal and State-specific requirements related to coverage and authorization of services are included. HSAG recommends that **Kaiser** update or clarify its policies and procedures to include that:

- Limits are not placed on family planning services, including the provider or the type of family planning method, and members are free from coercion and can choose the method of family planning to be used.

- All medically necessary treatments for covered behavioral health diagnoses, regardless of any co-occurring conditions, are covered. The diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service.
- **Kaiser** does not deny payment for emergency services when a **Kaiser** representative instructed the member to seek emergency services.
- Peer-to-peer opportunities are pursued, when necessary, prior to making a denial determination. In sample four of the denial record reviews, **Kaiser** reviewer notes and the Notices of Adverse Benefit Determination (NABDs) state that **Kaiser** reviewers received minimal clinical documentation and "need additional information to be able to further review." However, documentation does not show peer-to-peer or provider outreach efforts.
- The count of days regarding member notices specify whether the days are working or calendar.

Kaiser should consult with the Department to further clarify any limits to speech, occupational, and physical therapy. The **Kaiser** member handbook states that 30 therapy visits per year for physical, occupational, and speech therapy combined are covered whether the purpose of the therapy is to maintain or improve functional capacity. The handbook also states that speech therapy is limited to treatment for speech impairments due to injury or illness of specific organic origin. The handbook states that many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long-term and chronic in nature. The member handbook also states that occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living. However, the Colorado Revised Statutes, Section 10-16-104, states 20 visits for each therapy type.

Required Actions

Kaiser did not consistently include all federal and State requirements in policies, procedures, and member documents. **Kaiser** must revise its policies, procedures, and the member handbook to include all federal and State requirements such as:

- Monitoring adherence to the 10 calendar day time frame and addressing the factors **Kaiser** considers when deciding to expedite the decision and notice to the member.
- Including the complete definition of "medically necessary."
- Addressing the exceptions to the 10-day notice required before the reduction, suspension, or termination of a previously authorized CHP+-covered service. Either state that **Kaiser** does not suspend, terminate, or reduce a previously authorized CHP+ covered service or address a process for doing so that includes federal and State requirements.
- Ensuring that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that the determination is binding for **Kaiser**, which is responsible for coverage and payment.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

Kaiser submitted policies, procedures, network adequacy plans, and detailed descriptions of committees engaged in monitoring and ensuring a sufficient network of providers. In addition to quarterly and annual network adequacy reports and plans, **Kaiser** monitored access to care through dashboards that sourced data from appointment systems.

Staff members described an increased focus on primary care provider (PCP) appointments during the review period, culminating in adding 20 percent capacity, moving providers from 50 to 70 percent availability for new members, and adding daily appointment slots for adults and children (16 to 20 and 19 to 22 daily appointments, respectively). The document *KP Access Goals, Dashboards, and Management* listed access "levers," which included float support staff members to backfill in cases of medical leave, regular membership monitoring and recruitment efforts to address service demand, prioritization of clinical hours over administrative time, reducing duplication of member appointments, vetting appointments for the appropriate level staff, and using staff members for virtual care if able to do so during coronavirus disease 2019 (COVID-19) quarantine restrictions.

Female members had the right to direct access to a women's healthcare specialist, which was shared with members through the member handbook, referred to by **Kaiser** as the Evidence of Coverage (EOC) and operationalized internally as evidenced in the *Self-Referral to Specialty Reference Sheet*. Extended appointment hours on weekdays and weekend appointments were available, and **Kaiser** offered member services call centers, telehealth services, nurse advice lines, behavioral health access, and physical health appointments.

Although **Kaiser** did not report any single case agreements in effect during the review period, staff members described how out-of-network providers are informed that the cost to the member is no greater than in-network and described how single case agreements would be processed in a manner that would not delay the timeliness of service delivery.

Documentation included a description of how **Kaiser** ensures members with physical and mental disabilities are provided access and reasonable accommodations through the extensively detailed *Equal Access to Facilities, Services, and Programs* policy.

Opportunities for Improvement and Recommendations

Quarterly network adequacy validation (NAV) reports, annual reports, and reports such as the *CHP+ Quarterly Network Adequacy Tracker for Oversight Committee* demonstrated that **Kaiser**'s network access did not consistently adhere to time and distance standards in Douglas County for:

- Psychiatric hospitals and acute care facilities which met standards 98 percent of the time, falling just short of the 100 percent standard according to the NAV Quarter 4 (Q4) FY 2021–2022 reports.

While **Kaiser** reported the average drive time was around 20 minutes, HSAG recommends exploring any other available contracting opportunities in Douglas County.

- Endocrinology and pulmonology, for which reporting showed that one to three members within the small populations of six to eight pregnant members did not have access within time and distance standards, although **Kaiser** described that a facility is available in Lone Tree in northern Douglas County.
- Finally, quarterly NAV reports showed a deficiency in physician assistant (PA) access; however, **Kaiser** reported 95.5 to 100 percent compliance with PCP access. **Kaiser** noted that "there is no stipulation in the KPCO contract that we must meet the Primary Care requirements for PAs only." NAV reports showed a decrease in PA accessibility in more recent quarters despite the count of PA providers remaining the same. It appears that the member population may have experienced a change between Q3 and Q4 FY 2021–2022. HSAG recommends that **Kaiser** seek opportunities to expand the care network in Douglas County to ensure adequate network providers and member access to care according to the minimum time and distance standards, particularly for psychiatric hospitals.

While many of **Kaiser**'s hotlines and call centers had extended hours on weekdays and weekends, some with 24/7 or "immediate" availability, **Kaiser** did not consistently specify how the call centers and clinical staff operationalized to meet timely access to care and service standards for behavioral health within policies, procedures, or other evidence. Furthermore, **Kaiser** did not submit evidence that these standards were communicated to delegate entities or that **Kaiser** support staff members were trained to be aware of the requirements. HSAG recommends further detailing behavioral health timely access standards by phone, in person, and outpatient follow-up appointments after discharge from hospitalization.

During the interview, staff members were not able to provide an overview of the **Kaiser** CHP+ population, subgroups, and any identified trends in cultural attitudes, values, customers, or beliefs that could affect access to or benefits from healthcare services or risks associated with the member population. However, **Kaiser** did describe ongoing efforts to train staff members through the *Belong at KP* content that includes topics such as: breaking bias, cultivating belonging, and respecting every voice. Staff members stated that the content is regularly updated and that staff adhere to the *Commitment to Equity, Inclusion, and Diversity* policy. Staff members also described that social determinants of health data and language preferences for members were collected at onboarding. HSAG recommends expanding mechanisms to monitor and identify CHP+ populations that may benefit from outreach, education, and specialized access related to cultural needs.

Staff members clearly explained, during the interview, the department and management responsibilities regarding identification and reporting of any unexpected or anticipated material changes to the network or a network deficiency that could affect service delivery, availability, or capacity within the network. However, the time frame to submit a *Network Changes and Deficiencies Report* to the Department was not included within any policies or procedures. HSAG recommends updating internal documents to outline how **Kaiser** will meet the five-day timeline.

Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

Kaiser submitted its grievance and appeal policies and procedures, member handbook, provider handbook, and notice templates that defined and provided information that supported **Kaiser**'s implementation of requirements related to grievance and appeal systems. **Kaiser** also had a standard system, METRS, which tracks all information and data related to grievances and appeals. The system also captured member inquiries received by member services. **Kaiser** described its process to review grievances and appeals to identify trends. If trends are identified, **Kaiser** has a process to implement quality improvement initiatives to improve the grievance and appeal process.

A review of case files identified that **Kaiser** consistently met the standard and expedited time frames for providing grievance and appeal oral and written acknowledgement and resolution notices to members. **Kaiser** had well-documented processes to ensure that individuals who made decisions on grievances and appeals were not involved in any previous level of review. The case file review confirmed the implementation of these processes.

Kaiser produced grievance and appeal notices at an easy-to-understand level, at or around the sixth-grade reading level. From the case file review, **Kaiser** consistently met the timeliness requirements for grievance and appeal acknowledgement and resolution notices.

Opportunities for Improvement and Recommendations

HSAG recommends that **Kaiser** update its member handbook to clarify that grievances are resolved within 15 *working* days of when the member files the grievance. Additional updates are recommended to clarify that "State review" and "State review hearing" is a "State fair hearing" to align with federal and State requirements.

Required Actions

Kaiser did not consistently include all federal and State grievance and appeal requirements in its policies, procedures, and member documents. **Kaiser** must revise its internal and external documents to include all federal and State requirements, including that:

- With the member's written consent, a provider or authorized representative may file a grievance.

- The process implemented by **Kaiser** provides members with assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
- The parties to an appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.
- **Kaiser** shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.
- The parties to the State fair hearing include **Kaiser**, the member and their representative, or the representative of a deceased member's estate.

Regarding timelines, **Kaiser** must update its policies and procedures to consistently specify the correct time frame for acknowledgement and resolution notices to members. **Kaiser** must review its policies, procedures, and member handbooks to specify calendar or working days in all time frames referenced in the documents. The member handbook must state that **Kaiser** will resolve the appeal as expeditiously as the member's health condition requires (including the oral and written resolution process) and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). Documents must also be updated to replace the term "external appeal" with "State fair hearing" to align with federal and State requirements.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

Kaiser's *Medicaid Membership Narrative* described organizational processes to receive CHP+ membership enrollments directly from the State 834 enrollment file for processing either electronically or manually. **Kaiser** staff members reported that the majority of enrollments are received electronically from the Department through a secure file transfer site. Once the files are received, the files are converted to Personal Computer Group Automated Enrollment (PC GAE) files before processing in **Kaiser**'s membership system, Common Membership. Staff members further described that the State portal is the "source of truth" for any cases that need further validation of enrollment. **Kaiser** provided the *Colorado Medicaid State/Plan Partner Enrollment Process Flow* to demonstrate a clear overview of how **Kaiser** uploads the 834 enrollment files for data processing, review, and correction of errors. Daily change files and monthly full files are received from the Department to audit and evaluate against current membership for any issues.

Kaiser provided a nondiscrimination policy, and staff members reported that **Kaiser** processes the enrollment files as the files are received without discrimination and no member is excluded. Additionally, **Kaiser** staff members reported that they had not received any grievances or complaints related to enrollment. Within **Kaiser**'s document submission, staff members reported that they do not request disenrollment due to an adverse change in the member's health status, utilization of medical services, diminished mental capacity, behavior resulting from the member's special needs, or failure to pay a copayment if the member is a child. In all cases, disenrollment is determined by the Department.

During the interview session, staff members described mechanisms to report when a member is outside of the service area or ages out of CHP+, but it is the Department's ultimate decision to determine disenrollment. Additionally, when **Kaiser** does get assigned a member who may have other healthcare coverage or is outside of the service area, **Kaiser** sends a monthly report to the Department for further research and consideration.

Staff members explained how **Kaiser** handles uncooperative or disruptive behavior from a member, including policies within the care delivery space to help healthcare providers manage these situations, should they occur. Furthermore, **Kaiser** will work with the member to find another provider or offer care coordination services; disenrollment is the last resort unless the member prefers to be disenrolled.

CHP+ members are made aware of how to request disenrollment "for cause" in the member handbook, which the member receives during onboarding and is located on the member-facing website. **Kaiser** staff members explained that if the member has a question regarding enrollment or eligibility questions or requests, **Kaiser** staff will direct the member to call the Health First Colorado eligibility line. However, staff members described methods to ensure a warm handoff by staying on the phone with the member while the member calls the eligibility line, using community support specialists to navigate more detailed questions from the member, and **Kaiser**'s national Medicaid Assistance Center (MAC) to help answer questions.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the CHP+ MCO's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all CHP+ MCO denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the CHP+ MCO 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 I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The compliance 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 compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI).

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the CHP+ MCO regarding:

- The CHP+ MCO'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 CHP+ MCO 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 CHP+ MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the CHP+ MCO's services related to the standard areas reviewed.

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each CHP+ MCO 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 CHP+ MCO 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 CHP+ MCO 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 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—QAPI.

Related to Standard IV—Member Rights, Protections, and Confidentiality, **Kaiser** was required to complete two corrective actions, including:

- Reinstating or developing a policy that includes all member rights.
- Ensuring member rights policies and procedures include the member's right to receive information in accordance with federal requirements and be free from restraint, seclusion, and discipline for convenience.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in February 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **Kaiser**. **Kaiser** submitted draft policies in June 2022 and finalized the policies in July 2022.

Summary of Continued Required Actions

Kaiser successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Appendix A. Colorado Department of Health Care Policy & Financing FY 2022–2023 Compliance Monitoring Tool for Kaiser Permanente

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B—11.11.1	UM Program Description 2022, Purpose and Goals, pages 6-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B—11.11.3	Authorization of Services Policy ID#: 6891-13, Paragraph 5.6, page 4 UM Program Description 2022, Purpose and Goals, (2nd to the last paragraph), page 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. *42 CFR 438.210(a)(4)*	Clinical Criteria for UM Decisions, Policy ID #: 6891-02 sections 2.0, 5.1-5.3, medical necessity and criteria, page 1-4 Authorization of Services, Policy ID #: 6891-13, 1st paragraph in section 5, page 1 section 5.5 – demonstrates review for medical necessity, page 3 UM Program Description 2022, Purpose and Goals, page 6-8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—11.11.2, 11.11.4.1, 11.11.4.2, and 11.11.4.2.2	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Family Planning page 23, Moral Objections page 24	
4. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)* Contract: Exhibit B—11.9.1.3	Clinical Criteria for UM Decisions, Policy ID #: 6891-02, sections 2.0, 5.1-5.3 for medical necessity and criteria), page 1-3 2022.2.21_KPCO_CHP_EOC_ENG_ADA, UM page 35, Mental Health Service page 64, Mental Health Exclusions 65	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development.	Authorization of Services, Policy ID #: 6891-13, sections 5.5 and 5.6, page 3-4 2022.2.21_KPCO_CHP_EOC_ENG_ADA, • Medically Necessary definition, pgs. 101-102 • Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services 65-67 (2nd bullet, 3 marker) • Outpatient Care, page 46-47 (2nd bullet, 1-2 marker) • Kaiser Permanente CHP+ Health Plan Covered Benefits Summary page 37-45 (2nd bullet, 1-2 marker)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)* Contract: Exhibit B—2.1.71 and 11.1.2 10 CCR 2505-10 8.076.1.8		
Findings: Kaiser's *Authorization of Services, Policy ID #: 6891-13* states that benefits are no more restrictive in amount, duration, and scope than that used in Colorado's Medicaid and CHP+ programs. The policy does not address quantitative and non-quantitative treatment limits. Kaiser's member handbook includes a definition for medically necessary. The definition does not include the requirements of disease and/or disorder that results in health impairments and/or disability; ability for a member to achieve age-appropriate growth and development; or ability for a member to attain, maintain, or regain function capacity. Kaiser's *Authorization of Services, Policy ID #: 6891-13* includes the requirements of the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.		
Required Actions: Kaiser must update its member handbook to include the complete definition of "medically necessary" including: • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B—11.12.2	Authorization of Services, Policy ID #: 6891-13, Section 5.6, 5.7, page 4-5 Adverse Determination Policy, Section 5.1-5.3, page 1 KPCO does not delegate utilization management to subcontractors in the Denver/Boulder Service Area.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B—11.12.2	Inter-Rater Reliability (IRR) Assessment Policy ID #: 6891-14, Section 5.0, page 1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B—11.12.2.4	Authorization of Services Policy ID#: 6891-13, Section 5.8.2, page 7 Adverse Determinations Policy ID #: 6981-012, Section 5.6 for peer to peer, page 2-3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs.	Adverse Determinations Policy ID #: 6981-012, Section 5.3, page 1 Authorization of Services Policy ID#: 6891-13, Section 5.6, page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(b)(3) Contract: Exhibit B—11.11.5		
10. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B—8.5.1	Adverse Determinations Policy ID #: 6981- 012, Sections 5.7 (beginning paragraph) and 5.8, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—8.5.3.5; 8.5.3.7	Utilization Review Timeliness Policy ID# 6981-06, Section 5.3, page 2-3 Section 6.3, page 4 Section 7.3, page 6 Section 8.4, page 9	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Utilization Review Timeliness Policy ID# 6981-06* states that for CHP+ standard authorization decisions, utilization management shall make the determination and notify the member or member's representative and the provider/medical facility of the determination as expeditiously as the member's health condition requires, but no later than 10 calendar days after the receipt of the request. The policy also states that for CHP+ expedited authorization decisions, utilization management shall make the determination and notify the member or member's representative and the provider/medical facility of the determination as expeditiously as the member's health condition requires, but no later than 72 hours after the receipt of the request. However, the policy does not address the factors considered by Kaiser in expediting the decision and notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Staff members stated during the interview that they do not expedite authorization decisions unless requested by the provider. In one of the 10 sample denial records reviewed, the decision and notice to the member were sent on the eleventh calendar day.		
Required Actions: Kaiser must enhance its monitoring procedures to ensure standard authorization decisions are made as expeditiously as required and do not exceed 10 calendar days. Additionally, Kaiser must update its policy to address the factors considered in expediting the decision and notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Kaiser must expedite authorization decisions, when appropriate.		
12. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B—8.5.3.5.1-2; 8.5.3.7.1	Utilization Review Timeliness Policy ID#: 6981-06, Section 5.3.1, page 2-3 Section 6.3.1, page 4 Sections 7.3.1, and 7.3.2, page 6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor provides telephonic or telecommunications response within 24 hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B—11.9.2.2.1	Pharmacy Standard Work CHP Plus v4.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The notice of adverse benefit determination must be written in language easy to understand, available in state-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract: Exhibit B—8.5.1.1-4	Notice of Action – CHP+ Denial, Medical Necessity Notice of Action – Benefit Denial with Appeal Rights Page 8 Adverse Determinations Policy ID#: 6981-012, Sections 5.7.2 and 5.13, page 3-4 2022.2.21_KPCO_CHP_EOC_ENG_ADA CATLAR at end demonstrates non-English language assistance, page 108-109	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits).	Inform CHP+ MCOs that federal rule changes in May 2016 for CHIP excluded the requirement that member information include "benefits will continue when the member files an appeal." The Department CHP+ MCO contract removed the requirement in July 2021. Adverse Determinations Policy ID#: 6981-012, Sections 5.7 page 3 and 5.8 page 4 Notice of Action – CHP+ Denial, Medical Necessity	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12	Notice of Action – Benefit Denial with Appeal Rights Page 2-7	
16. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes their rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit.	Notice of Action – CHP+ Denial, Medical Necessity Notice of Action – Benefit Denial with Appeal Rights Page 6-7 Adverse Determinations Policy ID#: 6981-012, Sections 5.7 page 3 and 5.8 page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
HB19-1269: Section 6—10-16-113 (I), and (II), and (III) Contract: Exhibit B—8.5.1.13.1-3		
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract: Exhibit B—8.5.3.5-7	Utilization Review Timeliness Policy ID#: 6981-06, Sections 5.3, page 2-3 Section 6.3, page 4 Section 7.3, page 6 Section 8.4 page 7 Authorization of Services, Policy ID #: 6891-13, Section 5.6 last paragraph. Demonstrates once preauthorized, benefits cannot be retrospectively denied. Page 4 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 84, Appeals page 87-89	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services, or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Contractor establishes that the member has been accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination.	Utilization Review Timeliness Policy ID#: 6981-06, Sections Sections 5.3, page 2-3 Section 6.3, page 4 Section 7.3, page 6 Section 8.4 page 7 Authorization of Services, Policy ID #: 6891-13, Section 5.6 last paragraph. Demonstrates once preauthorized, benefits cannot be retrospectively denied, page 4	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.404(c) *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B—8.5.3.1-2 and 8.5.3.3.1-8		
Findings: Kaiser's *Utilization Review Timeliness Policy ID#: 6981-06* and *Authorization of Services, Policy ID #: 6891-13* and other submitted policies did not include the requirements of this element or state that Kaiser does not deny previously authorized services. During the interview session, Kaiser stated that it does not reduce or suspend a service once an authorization has been given; however, this was not documented in policies or procedures, and page 84 of the EOC indicates that Kaiser may deny a previously authorized service.		
Required Actions: Kaiser must update its policies and procedures to address the exceptions to the 10-day notice required before the reduction, suspension, or termination of a previously authorized CHP+-covered service. And Kaiser should either state that Kaiser does not deny previously authorized services (as recommended during the FY 2019–2020 review) or address a process for doing so that includes federal and State requirements.		
19. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B—8.5.3.5.2	Utilization Review Timeliness Policy ID #: 6891-06, Section 5.3.1.3, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B—11.12.6	Utilization Management Program Description, Page 30 last paragraph	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.37.1-3	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.1, page 1 Appendix A Glossary of Terms "Emergency Medical Condition (CHP+)", page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
22. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.38	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.1, page 1 Appendix A Glossary of Terms "Emergency Medical Condition (CHP+)", page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.87	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.2.1, page 1 Appendix A Glossary of Terms "Post-Stabilization Care Services (CHP+)", page 3 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor does not require prior authorization for emergency services or urgently needed services. *42 CFR 438.10(g)(2)(v)(B)* Contract: Exhibit B—11.9.4.8	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Sections 1.1 and 5.1.1, page 1 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 20-22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B—11.9.4.2	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.1.2, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)*	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.1, page 1 Appendix A Glossary of Terms "Emergency Medical Condition (CHP+)", page 2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Urgent care page 20-22 Emergency Medical Condition page 99 Emergency Services page 100	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B—11.9.4.4.1-2		
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B—11.9.4.5 and 11.9.4.15.3	Coverage of Emergency Services and Post Stabilization Care Policy ID #: 6891-03, Section 5.1, page 1 Appendix A Glossary of Terms "Emergency Medical Condition (CHP+)", page 2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Urgent care page 20-22 Emergency Medical Condition page 99 Emergency Services page 100	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B—11.9.4.6	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.3.1, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.3.1, page 2	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B—11.9.4.9		
Findings: The *Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03* states that the plan provider and the treating provider of the noncontracted facility both agree that the member is clinically stable for transfer. The policy does not state that the attending emergency physician, or the provider actually treating the member, are responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for payment. During the interview session, Kaiser stated that the implemented process allows the attending or treating physician to determine when the member is sufficiently stabilized for transfer or discharge.		
Required Actions: Kaiser must update its *Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03* to state that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for coverage and payment.		
30. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* Contract: Exhibit B—11.9.4.10	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.4 (1st paragraph) and 5.2.4.1, page 2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)*	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.4.2, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 422.113(c)(2)(ii) Contract: Exhibit B—11.9.4.11		
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* Contract: Exhibit B—11.9.4.11.1-3	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.4.3, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer,	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.5, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B—11.9.4.13.1-4		
34. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B—11.9.4.12	Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03, Section 5.2.6, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	88%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: primary care (adult and pediatric), OB/GYN providers, specialists, hospitals, pharmacies, and behavioral health (mental and substance use disorder, adult and pediatric). *42 CFR 438.206(b)(1)* Contract: Exhibit B—9.1.1; 9.3.1; 9.5.1.1	Network Adequacy and monitoring Procedure_final Provision 5.0., page 2 - This policy identifies how the company evaluates the availability of practitioners and provider performance to the standards. The process through which the company monitors availability is provided. Network Adequacy Management and Oversight Policy_final, Section 1.0, 2.0, 5.1, 5.1.3, page 1 Section 5.2 page 2 Kaiser Permanente Colorado Provider Directory Accuracy Report 2022, Attestation process, page 2 chp-provider-directory-co-en CO Network Adequacy_Q3 Report Word Template_F1_0322 CO2021-22_NAV_FY 2022 Q3 QuarterlyReport_GeoaccessCompliance_CHP+ MCO_Kaiser	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes	Network Adequacy and monitoring Procedure_final, Section 1.0, 4.0, page 1 5.6.3, page 6 5.10, page 8 Appendix B, page 12-13 Network Adequacy Management and Oversight Policy_final, Section 1.0, 5.4, 5.5, page 2-4 CO Network Adequacy_Q3 Report Word Template_F1_0322 CO2021-22_NAV_FY 2022 Q3 QuarterlyReport_GeoaccessCompliance_CHP+ MCO_Kaiser	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – frontier counties—60 miles or 60 minutes *42 CFR 438.206(a)* Contract: Exhibit B—9.3.10		
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes	Network Adequacy and monitoring Procedure_final, Section 1.0, 4.0, page 1 5.6.3, page 6 5.10, page 8 Appendix B, page 12-13 Network Adequacy Management and Oversight Policy_final, Section 1.0, 5.4, 5.5, page 2-4 CO Network Adequacy_Q3 Report Word Template_F1_0322 CO2021-22_NAV_FY 2022 Q3 QuarterlyReport_GeoaccessCompliance_CHP+ MCO_Kaiser	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B—9.3.11.2)* *42 CFR 438.206(a)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1		
4. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B—9.3.13	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Women Health Specialist page 35	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B—9.3.22	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Second Opinion page 34-35	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must cover the services (timely and without compromising the member's quality of care or health) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B—9.3.23.1	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Payment page 32	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B—9.3.23.2	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Member costs page 17, Contracts with Network Providers page 93-94	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need.	2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 27-28 Member Access to Care, Routine 5.2 page 2, Urgent Care 5.4 page 3, BH 5.8 page 4-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule). • Outpatient follow-up appointments within seven days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17		
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to other CHP+ providers. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service staff. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B—7.3.4.2; 9.3.5-9.3.6.1	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Urgent Care page 20, Where to Get Care page 23, Appointments Page 31 Medical Offices Hours and Location Example chp-provider-directory-co-en, Emergency and Urgent Care Page 3, Nondiscrimination notice Page 9 668986774_21_CHP+_NewMemberGuidebook_v6, Get Connected page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B—9.3.8; 9.3.9; 9.3.17.1; 11.9.4.7	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Where to Get Care page 23 Member Access to Care, Section 5.5, page 3 668986774_21_CHP+_NewMemberGuidebook_v6, Get Connected page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance, including research to determine solutions for any causal systemic issues. • Taking corrective action and notifying the Department if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B—9.3.17-9.3.19	Network Adequacy and monitoring Procedure_final, Section 1.0, 4.0, page 1 5.6.3, page 6 5.10, page 8 Appendix B, page 12-13 Network Adequacy Management and Oversight Policy_final, Section 1.0, page 1 5.4, 5.5, page 2-4 PY2022 Colorado OneKP Access Plan_FINAL, Page 2, Page 5 CO Network Adequacy_Q3 Report Word Template_F1_0322 CO2021-22_NAV_FY 2022 Q3 QuarterlyReport_GeoaccessCompliance_CHP+ MCO_Kaiser	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Developing and/or providing cultural competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members during orientation or while being served by providers. *42 CFR 438.206(c)(2)* Contract: Exhibit B—2.1.27; 7.2	chp-provider-directory-co-en, Serving Members with Diverse Backgrounds and Physical Accommodations, Page 3, Non discrimination notice, page 4 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Other Language page 5-6, General Policy Provisions page 92, Nondiscrimination page 95 Belong at KP Overview This document illustrates the diversity training requirements for Kaiser Permanente CO employees. Commitment to Equity, Inclusion, and Diversity.pdf, 1.0, 5.0, page 1 5.3 , page 2 Note: document difficult to highlight Equal Access to Facilities, Services, and Programs (1203_1), 1.0, 2.0, page 1 Definitions 1508 updated 2021 (1), RELP Page 1-2 - New Member onboarding screening script KPCO Provider Manual_Section 6 Provider Rights, Provider Rights and Responsibilities Page 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor must ensure that network providers have the ability to provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B—9.1.6.7	chp-provider-directory-co-en, Physical Accommodations, Page 3, Non discrimination notice, page 4 Equal Access to Facilities, Services, and Programs (1203_1), Section 1.0, 5.2-5.6, page 1-2 KPCO Provider Manual_Section 6 Provider Rights, Office Requirements Page 8 and 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is adequate in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A *Network Adequacy Plan* is submitted to the State annually. • A *Network Report* is submitted to the State quarterly. • A *Network Changes and Deficiencies Report* is submitted to the State within five days after the Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the network. *42 CFR 438.207(b)* Contract: Exhibit B—9.4-9.5	Kaiser Permanente Colorado Provider Directory Accuracy Report 2022 CO Network Adequacy_Q3 Report Word Template_F1_0322 CO2021-22_NAV_FY 2022 Q3 QuarterlyReport_GeoaccessCompliance_CHP+ MCO_Kaiser Maps, CHP+ Membership and Provider Map	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	100%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B—8.1 10 CCR 2505-10 8.209.1	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 70, Grievance System 7.26 KP CHP Quarterly Grievance and Appeals report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 67, CHP+ Adverse Benefit Determination (ABD) 7.2.2 KPCO Provider Manual_Section 7 Member Rights, page 12 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 84 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.1 10 CCR 2505-10 8.209.2.A		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.3 10 CCR 2505-10 8.209.2.B	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 68, Appeal 7.4 KPCO Provider Manual_Section 7 Member Rights, page 12 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 84 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested.	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 70, CHP+ Grievance 7.25.2 KPCO Provider Manual_Section 7 Member Rights, page 11 2022.2.21_KPCO_CHP_EOC_ENG_ADA, page 86	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.50 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.i		
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used, it includes providers and authorized representatives acting on behalf of the member.* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—8.5.1.7; 8.6.5	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 8, Right to File 5.18 Page 61, CHP 6.9.4.2 Page 73, Representative (Appointed/Authorized) 7.50 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 86-89 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ member handbook describes the process to file a grievance by phone, mail, in-person, and online. It does not inform the member that with their written consent, a representative or provider may file the grievance on their behalf. It also describes the process to file an appeal by phone, mail, in-person, and online. The appeal section states that with the member's written consent, a representative or the provider can help file an appeal for the member. The member handbook describes the process for the member to file a state review but does not clarify that a state review is a State fair hearing.		
Required Actions: Kaiser must update its member handbook to state that with the member's written consent, a provider or authorized representative may file a grievance.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability. *42 CFR 438.406(a)* CHP+ Contract: Exhibit B—8.2 10 CCR 2505-10 8.209.4.C	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 8, Intake 6.1 Page 3, Alternative Formats 5.2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 86-89, 108	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* states that program representatives shall ensure all individuals have access to, and can fully participate in, the grievance system by providing assistance for those with a visual or other communicative impairment. Such assistance shall include, but is not limited to, telephone relay systems and other devices that aid disabled individuals to communicate. The program representative shall ensure that the alternative format offered to individuals results in effective communication. Alternative formats include large print, electronic documents, audio compact discs, and Braille. The CHP+ member handbook includes TTY 711, toll-free numbers, and interpreter services. However, the policy does not state these rights are also included in the appeal system. Documents did not describe how Kaiser gives members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.		
Required Actions: Kaiser must update its policies, procedures, and the member handbook to include providing member assistance in completing any forms and taking other procedural steps related to a grievance or appeal.		
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following:	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 33, Decision/Committee Review 6.5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.4.4; 8.6.3 10 CCR 2505-10 8.209.5.C, 8.209.4.E		
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.5.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 34, Appeal Decision Makers 6.5.5.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.D	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 8, Acceptance and Facilitation of a case 6.1.1 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 86	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.A	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 9, Filing Timeframes and Methods Table 6.1.2 Page 10, CHP+ Filing Timeframes and Methods Table 6.1.5 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 86	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.4.5 10 CCR 2505-10 8.209.5.B	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 25, Standard Acknowledgement Timeframes and Methods Table 6.3.2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 87	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's member handbook states that within two days of the member making the complaint, Kaiser will send the member a letter letting the member know that Kaiser is working on the complaint. It does not state that the written acknowledgement will be sent within two working days.		
Required Actions: Kaiser must update the member handbook to state that the grievance acknowledgment letter will be sent within two working days.		
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract: Exhibit B—8.4.6; 8.4.8 10 CCR 2505-10 8.209.5.D	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 41, Resolution 6.7.1 Page 43, Resolution Timeframes and Methods Table 6.7.2 Page 7, CHP+ Readability 5.15.1 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 87	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* CHP+ Contract: Exhibit B1—8.4.6. 10 CCR 2505-10 8.209.5.G	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 47, Resolution Requirements, Section 6.7.7 Medicaid GRV Res_0, page 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 50, CHP+ 6.7.8.6 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 87 – explains that there is only one level of appeal for members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B—8.6.5.1 10 CCR 2505 10 8.209.4.B	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 9, Filing Timeframes and Methods Table 6.1.2 Page 10-11, CHP+ Filing Timeframes and Methods Table 6.1.5 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* CHP+ Contract: Exhibit B—8.6.5.2 10 CCR 2505 10 8.209.4.F	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 8, 6.1.1 Page 9, Filing Timeframes and Methods Table 6.1.2 Page 10, CHP+ Filing Timeframes and Methods Table 6.1.5 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 25 CHP+ Standard Acknowledgement Timeframes and Methods Table 6.3.2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's member handbook states that within two days of receiving the appeal, Kaiser will send the member a letter letting the member know that Kaiser received the appeal. It does not state that the written acknowledgement will be sent within two working days.		
Required Actions: Kaiser must update the member handbook to state that the appeal acknowledgment letter will be sent within two working days.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—8.6.11 10 CCR 2505-10 8.209.4.I	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 13, Authorized Representation 6.1.8	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* states that All Health Plan members have the right to be represented by an individual to act on their behalf, upon receipt of appropriate legal authorization and/or documentation of the representative. The policy does not describe that parties to the appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.		
Required Actions: Kaiser must update its policies and procedures to clarify that parties to an appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.		
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 29, CHP+: For all Appeals, the opportunity to present testimony 6.3.8 Page 47, Resolution Requirements 6.7.7.3 Page 33, New Evidence during an appeal 6.4.10 CHP+ Appeal Rights, page 1 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406(b)(4-5) CHP+ Contract: Exhibit B—8.6.8-8.6.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H		
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* CHP+ Contract: Exhibit B—8.6.12; 8.6.13.2 10 CCR 2505-10 8.209.4.Q-R	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 13 section 6.1.8 Page 21, Expedited Criteria 6.2.2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B—8.6.13.2.2 10 CCR 2505-10 8.209.4.S	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 10, CHP+ Filing Timeframes and Methods Table 6.1.5 Page 14 Cases Not Meeting Expedited Review 6.1.12.2 Page 15 CHP+ Notification Timeframes for Cases Not Meeting Expedited Review 6.1.12.3.5 Page 22, Cases not meeting Expedited Review 6.2.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals Page 41, Resolution Timeframes 6.7 Page 43, CHP+ Resolution Timeframes and Methods 6.7.3 Page 7, CHP+ Readability 5.15.1 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 1	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP+ member handbook states that within 10 days, Kaiser will send the member a letter with Kaiser's decision on the member's appeal. It does not describe the member resolution notification process.		
Required Actions: Kaiser must update the CHP+ member handbook to clarify that for standard appeals, Kaiser will provide the resolution notice within 10 working days from the day Kaiser receives the standard appeal. HSAG also recommends clarifying the oral and written process of expedited resolutions if the request for a standard appeal is deemed to require a resolution in a more expeditious manner.		
23. For expedited appeals, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B—8.6.13.2.3; 8.6.13.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, page 41 of the policy section 6.7.1.1 Page 43, CHP+ Resolution Timeframes and Methods 6.7.3 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 2	
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—8.4.7; 8.6.13.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Pages 35, Extensions (Grievance) 6.6 Page 39, Extensions (Appeals) 6.6.3 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 2	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* does not include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.		
Required Actions: Kaiser must update its policies and procedures to include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B—8.4.7.1; 8.6.13.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 35, Extensions Grievance 6.6.1.3.1 Page 39, Appeals 6.6.3.1.2-4 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 88 CO Access KP CHP+ EOB Appeal Attachment_April 2022, page 2	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's CHP+ member handbook states that the member can ask for more time for a decision on the appeal and Kaiser can ask for more time, up to 14 days, if more information is needed. Kaiser will send the member a letter within two days if Kaiser needs more time to decide. The EOB appeal rights notice also does not describe the oral and written process for the resolution notice.		
Required Actions: Kaiser must update the CHP+ member handbook to inform the member that within two calendar days, Kaiser will give the member written notice of the reason for the delay and to inform the member of the right to file a grievance if the member disagrees with that decision. The member handbook must also state that Kaiser will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The written notice of appeal resolution must include: • The results of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M	In May 2016, the federal rule changes for CHIP excluded from the requirement that member information must include "benefits will continue when the member files an appeal." However, the Department removed the statement from the CHP+ MCO contract requirement in July 2021. CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 47, Resolution Requirements 6.7.7 Page 50, The right to request State Fair Hearing 6.7.8.6.2 CHP+ Appeal Rights, page 1 Medicaid Adverse_0, the letter is dated with the mail date, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)*	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 5, Deemed Exhaustion/State Fair Hearing 5.9.2 page 50 section 6.7.8.6.2 2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 87, 89	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—8.6.14.1 10 CCR 2505-10 8.209.4.N and O	CHP Appeal Rights, page 1-4	
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—8.6.14.3	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 89 CHP Appeal Rights, page 3-4	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's CHP+ member handbook does not state that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate. The *CHP Appeal Rights* document also does not include the requirement that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate.		
Required Actions: Kaiser must update its CHP+ member handbook and the *CHP Appeal Rights* document to state that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate.		
29. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424* CHP+ Contract: Exhibit B—8.6.13.4 10 CCR 2505-10 8.209.4.W	2022.2.21_KPCO_CHP_EOC_ENG_ADA, Page 89 CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 52, Effectuation CHP+ 6.8.1.3.2 CHP Appeal Rights, page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department's quality strategy. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B—8.1; 8.7 10 CCR 2505-10 8.209.3.C	CO Policy CO.MR.004 Non-Medicare Grievance & Appeals, Page 5, Documentation 5.10 Page 6, File Retention 5.12 Page 7, section 5.16 KP CHP Quarterly Grievance and Appeals report - It is evidenced by the Quarterly reporting that the Plan submits to the Dept on a routine basis the following: - Volumes - Quarterly report to capture grievance acknowledgments and resolution timeframes including volumes measured in 6 different categories: Access and Availability, Clinical Care, Customer Service, Financial/Billing, Rights/Legal, Enrollment/Disenrollment/Eligibility and Benefits Package.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B	KPCO Provider Manual_Section 7 Member Rights Page 6 CHP+ Member Rights Page 10 CHP+ Grievances Page 13 CHP+ Appeals Page 15 State Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	9	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	22
Total Score ÷ Total Applicable						=	71%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract. • The Contractor may not apply limits to newborns. • In the event that the Contractor reaches the enrollment limits, the Contractor shall notify the Department. *42 CFR 438.3(d)(1)* Contract: Exhibit B—6.3.3; 6.3.7	Kaiser does not have enrollment limits for CHP+ and does not apply any limits to Newborns. Newborns are enrolled into the same CHP+ plans as Child and Prenatal members. Medicaid Membership Narrative 07.05.2022_FINAL page, for processing of full files Section 3.1.3-3.1.4, page 12-13 Section 3.4.1.2, page 16 KP_CHP_EOC_updates for 7.1.2022_ENG_final, Newborn Enrollment page 12	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR 438.3(d)(3-4)* Contract: Exhibit B—6.3.3.1	Nondiscrimination in the Provision of Healthcare (1202_3) – Section 1.0, 5.1, page 1 KP_CHP_EOC_updates for 7.1.2022_ENG_final, Nondiscrimination, page 96 Colorado CHP+ Member Rights Policy (6334_0) – Section 5.1, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services • Diminished mental capacity or adverse changes in the member's health status.	Kaiser does not request disenrollments for any of these reasons listed and disenrollment is determined by the State. Medicaid Membership Narrative 07.05.2022_FINAL, section 3.3, page 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Behavior (e.g., uncooperative or disruptive) resulting from the member's special needs (except when the member's continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). • Failure to pay a copayment if that member is a child. *42 CFR 438.56(b)(2)* Contract: Exhibit B—6.5.2.2	Membership Termination for Cause, 5.1.1.2 - Note: document is difficult to highlight	
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or to other members. • For cause, at any time under the following circumstances: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk	Kaiser follows disenrollment guidance provided by the State and does inform the State when disenrollment may be applicable. Medicaid Membership Narrative 07.05.2022_FINAL, section 3.3, page 24 Membership Termination for Cause, 5.1.1.2 – Note: document is difficult to highlight Monthly Membership Report to Denver Health, page 1 and 2 See example of CHP Disenrollment Reports	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs *42 CFR 438.56(b)(1)* Contract: Exhibit B—6.5.5.1		
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* Contract: Exhibit B—6.5.2.1.9.3.1	Kaiser provides the following reports to the State when disenrollment may be applicable. Monthly Membership Report to Denver Health, page 1 and 2 See example of CHP Disenrollment Reports	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area – The Contractor does not (due to moral or religious objections) cover the service the member needs	Kaiser directs members to call the State with any enrollment or eligibility questions or requests. KP_CHP_EOC_updates for 7.1.2022_ENG_final, Who Can Become a Member page 8 Ending your Enrollment, page 12, Add Moral Objection, page 24	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error – Poor quality of care – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs • Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4) *42 CFR 438.56(c)-(d)(2)* Contract: Exhibit B—6.5.5		

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for Kaiser Permanente

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	October 29, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Amy Archer, Utilization Management Medical Audit Coordinator

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	1/20/2022	1/21/2022	1/29/2022	2/10/2022	3/3/2022	4/13/2022	5/5/2022	5/16/2022	7/8/2022	9/15/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	S	E	S	S	S	S	S	S	E					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/28/2022	2/1/2022	2/1/2022	2/20/2022	3/13/2022	4/22/2022	5/12/2022	5/26/2022	7/16/2022	9/16/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/30/2022	2/1/2022	2/1/2022	2/20/2022	3/13/2022	4/22/2022	5/12/2022	5/26/2022	7/16/2022	9/16/2022					
Notice Sent to Provider and Member? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	8 D	11 D	3 D	10 D	10 D	9 D	7 D	10 D	8 D	1 D					
Number of Hours or Days for Notice (H/D)	10 D	11 D	3 D	10 D	10 D	9 D	7 D	10 D	8 D	1 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.11] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Not Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Not Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Authorization Decision Made by Qualified Clinician? [I.9]	Met	NA	Met	Met	NA	NA	Met	Met	Met	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.8]	NA	NA	NA	Not Met	NA	NA	NA	NA	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	7	6	7	8	6	6	7	7	7	7					
Compliant (Met) Elements	7	4	7	7	6	6	7	7	7	7					
Percent Compliant	100%	67%	100%	88%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**68**														
Overall Total Compliant Elements	**65**														
Overall Total Percent Compliant	**96%**														

Comments: File 1: Date of the decision not accurate in the notice based on the date in the file. **File 2:** January 21st to February 1st is 11 calendar days. **File 4:** Reviewer notes and NABD state that Kaiser received minimal clincal documentation. Reviewer notes state "need additional information to be able to further review"; however, documentation does not show peer-to-peer or provider outreach efforts. **File 7:** Reason for denial is out-of-network, not medical necessity. Physician review notes state that the service met the requirements for necessity but was denied for out-of-network provider.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for Kaiser Permanente

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	October 29, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Tina Santos, Senior Consultant, Member Service Quality and Risk

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****										
Date Grievance Received [XX/XX/XXXX]	1/20/2022	4/14/2022	4/14/2022	5/13/2022	8/23/2022										
Date of Acknowledgement Letter [XX/XX/XXXX]	1/24/2022	4/18/2022	4/18/2022	5/17/2022	8/25/2022										
Days From Grievance Received to Acknowledgement	2	2	2	2	2										
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met										
Date of Written Notice [XX/XX/XXXX]	2/4/2022	4/28/2022	4/28/2022	6/2/2022	9/14/2022										
# of Days to Notice	11	10	10	13	15										
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met										
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met										
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	Met	NA	Met	NA										
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met										
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met										
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	6	5	6	5										
Compliant (Met) Elements	5	6	5	6	5										
Percent Compliant	100%	100%	100%	100%	100%										
Overall Total Applicable Elements	**27**														
Overall Total Compliant Elements	**27**														
Overall Total Percent Compliant	**100%**														

Comments: All cases are written in easily understood language. Member rights are included in each communication. However, tag lines do not include auxillary aids.

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for Kaiser Permanente

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	October 29, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Tina Santos, Senior Consultant, Member Service Quality and Risk

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****														
Date Appeal Received [XX/XX/XXXX]	2/23/2022														
Date of Acknowledgement [XX/XX/XXXX]	2/24/2022														
Days From Appeal Received to Acknowledgement	1														
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met														
Decision-Maker Not Previous Level [VI.7]	Met														
Decision-Maker—Clinical Expertise [VI.7]	NA														
Expedited Appeal: Yes or No	No														
Time Frame Extended: Yes or No	No														
Date Resolution Notice Sent [XX/XX/XXXX]	3/9/2022														
Hours or Days From Appeal Filed to Resolution Notice Sent	10 D														
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met														
Resolution Letter Includes Required Content [VI.26]**	Met														
Resolution Letter Easy to Understand [VI.22]	Met														
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5														
Compliant (Met) Elements	5														
Percent Compliant	100%														
Overall Total Applicable Elements	**5**														
Overall Total Compliant Elements	**5**														
Overall Total Percent Compliant	**100%**														
Comments:															

***Appeal resolution letter time frame** does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2022–2023 site review of **Kaiser**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Kim Elliott	Executive Director
Lauren Gomez	Project Manager I
Crystal Brown	Project Manager I
Kaiser Participants	**Title**
Amy Archer	Utilization Management Medical Audit Coordinator
Reginald Chambliss	Resource Stewardship Claims Authorization Processor
Jodie Shuss	Resource Stewardship Referral Manager
Kimberly Rhoades	Pharmacy Supervisor
Janine Vincent	Compliance Consultant
Cindy Huerta	Director, Utilization Management
Mikala Gibbs	Project Manager, Network Operations
Lauren Ambrozic	Regional Director, Consumer Experience
Rachael M. Ferguson	Senior Business Operations Manager
Renae Pemberton	Senior Director, Provider Contracting
Elizabeth Bradley	Project Manager, Provider Contracting
Brooke Eckles	Vice President, Consumer Experience
Tina Santos	Senior Consultant, Member Service Quality and Risk
Daisy Strickland	Regulatory Consultant, Member Service Quality and Risk
Nikki Fitt	Manager, Grievance Operations
Rhonda Rutherford	Regulatory Consultant, Member Service Quality and Risk
Rashida Tobar	Regulatory Consultant, Member Service Quality and Risk
Ericka M. Sandoval	Regulatory Consultant, Member Service Quality and Risk
Susan Osborne	Executive Director, Member Relations, Grievance Operations
Jason Devers	Director, Member Case Resolution
Diane Wymer	Business Consultant, Member Relations, Grievance Operations
Ericka Sandoval	Member Services Call Center Regulatory Consultant
Sandra Castro	Member Services Call Center Regulatory Consultant

Kaiser Participants	Title
Michele Q. ONeal	Business Consultant, Membership Administration
Megan X. Cheever	Director, Membership Administration
Chris Laidley	Senior Manager, Membership Administration
Shamica T. Brown	Manager, Membership Administration
Aaron M. Sampson	Senior Account Administrator, Membership Administration
Fey Saechao	Business Consultant, Membership Administration
Hiromi Fujita	Accounting Analyst, Membership Administration
Michelle D. Collins	Membership Liaison, Employer Services
James E. Conners	Data Management, Membership Administration
Janelle L. Castanares	Business Consultant, Membership Administration
Celestin Bimbi	Data Management Technical Lead, Membership Administration
Liz Chapman	Contract Manager, Medicaid and Charitable Programs
Kirsten Swart	Compliance Consultant
Casey Snow	Accreditation Specialist
Carlos Madrid	Senior Manager, Medicaid and Charitable Programs
Kathy Westcoat	Senior Director, Medicaid and Charitable Programs
Tracy Copeland	Project Manager, Medicaid and Charitable Programs
Janae H. Dacut	Compliance Consultant
Karen Thiel	Senior Counsel
Janet Lucchesi	Director of Accreditation
Department Observers	**Title**
Jeff Helm	Program Design and Policy
Helen Desta	Quality Section Manager
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2022–2023

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE 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 MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE 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 MCE 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 resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for Kaiser

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
5. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)* Contract: Exhibit B—2.1.71 and 11.1.2 10 CCR 2505-10 8.076.1.8
Findings
Kaiser's *Authorization of Services, Policy ID #: 6891-13* states that benefits are no more restrictive in amount, duration, and scope than that used in Colorado's Medicaid and CHP+ programs. The policy does not address quantitative and non-quantitative treatment limits. Kaiser's member handbook includes a definition for medically necessary. The definition does not include the requirements of disease and/or disorder that results in health impairments and/or disability; ability for a member to achieve age-appropriate growth and development; or ability for a member to attain, maintain, or regain function capacity. Kaiser's *Authorization of Services, Policy ID #: 6891-13* includes the requirements of the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.

Standard I—Coverage and Authorization of Services
Required Actions
Kaiser must update its member handbook to include the complete definition of "medically necessary" including: • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—8.5.3.5; 8.5.3.7
Findings
The *Utilization Review Timeliness Policy ID# 6981-06* states that for CHP+ standard authorization decisions, utilization management shall make the determination and notify the member or member's representative and the provider/medical facility of the determination as expeditiously as the member's health condition requires, but no later than 10 calendar days after the receipt of the request. The policy also states that for CHP+ expedited authorization decisions, utilization management shall make the determination and notify the member or member's representative and the provider/medical facility of the determination as expeditiously as the member's health condition requires, but no later than 72 hours after the receipt of the request. However, the policy does not address the factors considered by Kaiser in expediting the decision and notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Staff members stated during the interview that they do not expedite authorization decisions unless requested by the provider. In one of the 10 sample denial records reviewed, the decision and notice to the member were sent on the eleventh calendar day.

Standard I—Coverage and Authorization of Services
Required Actions
Kaiser must enhance its monitoring procedures to ensure standard authorization decisions are made as expeditiously as required and do not exceed 10 calendar days. Additionally, Kaiser must update its policy to address the factors considered in expediting the decision and notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Kaiser must expedite authorization decisions, when appropriate.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
18. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services, or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Contractor establishes that the member has been accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B—8.5.3.1-2 and 8.5.3.3.1-8

Standard I—Coverage and Authorization of Services
Findings
Kaiser's *Utilization Review Timeliness Policy ID#: 6981-06* and *Authorization of Services, Policy ID #: 6891-13* and other submitted policies did not include the requirements of this element or state that Kaiser does not deny previously authorized services. During the interview session, Kaiser stated that it does not reduce or suspend a service once an authorization has been given; however, this was not documented in policies or procedures, and page 84 of the EOC indicates that Kaiser may deny a previously authorized service.
Required Actions
Kaiser must update its policies and procedures to address the exceptions to the 10-day notice required before the reduction, suspension, or termination of a previously authorized CHP+-covered service. And Kaiser should either state that Kaiser does not deny previously authorized services (as recommended during the FY 2019–2020 review) or address a process for doing so that includes federal and State requirements.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B—11.9.4.9
Findings
The *Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03* states that the plan provider and the treating provider of the noncontracted facility both agree that the member is clinically stable for transfer. The policy does not state that the attending emergency physician, or the provider actually treating the member, are responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for payment. During the interview session, Kaiser stated that the implemented process allows the attending or treating physician to determine when the member is sufficiently stabilized for transfer or discharge.
Required Actions
Kaiser must update its *Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03* to state that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for coverage and payment.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard I—Coverage and Authorization of Services
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used, it includes providers and authorized representatives acting on behalf of the member.* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—8.5.1.7; 8.6.5
Findings
The CHP+ member handbook describes the process to file a grievance by phone, mail, in-person, and online. It does not inform the member that with their written consent, a representative or provider may file the grievance on their behalf. It also describes the process to file an appeal by phone, mail, in-person, and online. The appeal section states that with the member's written consent, a representative or the provider can help file an appeal for the member. The member handbook describes the process for the member to file a state review but does not clarify that a state review is a State fair hearing.
Required Actions
Kaiser must update its member handbook to state that with the member's written consent, a provider or authorized representative may file a grievance.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability. *42 CFR 438.406(a)* CHP+ Contract: Exhibit B—8.2 10 CCR 2505-10 8.209.4.C
Findings
Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* states that program representatives shall ensure all individuals have access to, and can fully participate in, the grievance system by providing assistance for those with a visual or other communicative impairment. Such assistance shall include, but is not limited to, telephone relay systems and other devices that aid disabled individuals to communicate. The program representative shall ensure that the alternative format offered to individuals results in effective communication. Alternative formats include large print, electronic documents, audio compact discs, and Braille. The CHP+ member handbook includes TTY 711, toll-free numbers, and interpreter services. However, the policy does not state these rights are also included in the appeal system. Documents did not describe how Kaiser gives members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
Required Actions
Kaiser must update its policies, procedures, and the member handbook to include providing member assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.4.5 10 CCR 2505-10 8.209.5.B
Findings
Kaiser's member handbook states that within two days of the member making the complaint, Kaiser will send the member a letter letting the member know that Kaiser is working on the complaint. It does not state that the written acknowledgement will be sent within two working days.
Required Actions
Kaiser must update the member handbook to state that the grievance acknowledgment letter will be sent within two working days.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D
Findings
Kaiser's member handbook states that within two days of receiving the appeal, Kaiser will send the member a letter letting the member know that Kaiser received the appeal. It does not state that the written acknowledgement will be sent within two working days.
Required Actions
Kaiser must update the member handbook to state that the appeal acknowledgment letter will be sent within two working days.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—8.6.11 10 CCR 2505-10 8.209.4.I
Findings
Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* states that All Health Plan members have the right to be represented by an individual to act on their behalf, upon receipt of appropriate legal authorization and/or documentation of the representative. The policy does not describe that parties to the appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.
Required Actions
Kaiser must update its policies and procedures to clarify that parties to an appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1
Findings
The CHP+ member handbook states that within 10 days, Kaiser will send the member a letter with Kaiser's decision on the member's appeal. It does not describe the member resolution notification process.
Required Actions
Kaiser must update the CHP+ member handbook to clarify that for standard appeals, Kaiser will provide the resolution notice within 10 working days from the day Kaiser receives the standard appeal. HSAG also recommends clarifying the oral and written process of expedited resolutions if the request for a standard appeal is deemed to require a resolution in a more expeditious manner.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—8.4.7; 8.6.13.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E
Findings
Kaiser's *CO Policy CO.MR.004 Non-Medicare Grievance & Appeals* does not include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.
Required Actions
Kaiser must update its policies and procedures to include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B—8.4.7.1; 8.6.13.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E
Findings
Kaiser's CHP+ member handbook states that the member can ask for more time for a decision on the appeal and Kaiser can ask for more time, up to 14 days, if more information is needed. Kaiser will send the member a letter within two days if Kaiser needs more time to decide. The EOB appeal rights notice also does not describe the oral and written process for the resolution notice.
Required Actions
Kaiser must update the CHP+ member handbook to inform the member that within two calendar days, Kaiser will give the member written notice of the reason for the delay and to inform the member of the right to file a grievance if the member disagrees with that decision. The member handbook must also state that Kaiser will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—8.6.14.3
Findings
Kaiser's CHP+ member handbook does not state that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate. The *CHP Appeal Rights* document also does not include the requirement that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate.
Required Actions
Kaiser must update its CHP+ member handbook and the *CHP Appeal Rights* document to state that the parties to the State fair hearing include the Contractor, the member and their representative, or the representative of a deceased member's estate.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in 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 desk request forms, compliance 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 MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE 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 MCE 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 MCE 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 MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs 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 MCE 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 MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance 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 Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE 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 MCE and the Department.