CHP+

Child Health Plan *Plus*

Fiscal Year 2024–2025 Compliance Review Report

for

Kaiser Permanente

February 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (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.

Kaiser Permanente (Kaiser) showed strong understanding of federal regulations by scoring 100 percent for all standards reviewed, which resulted in maintaining or improving these scores compared with the prior review of these standards.

Table 1-1 presents the scores for Kaiser for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	11	10	10	0	0	1	100%~
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%^
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%~
Totals	**48**	**47**	**47**	**0**	**0**	**1**	**100%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	77	77	77	0	0	100%~
Recredentialing	60	60	60	0	0	100%~
Totals	**137**	**137**	**137**	**0**	**0**	**100%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

Kaiser provided evidence of a thorough care coordination program which included a multidisciplinary team of experienced clinical and nonclinical staff members. The care coordination program was composed of four teams centering on the following areas: integrated care, complex care, pediatric care, and social work. Specifically, the Pediatric Complex Care team served high-risk pediatric members who were initially identified during the onboarding process, referred by their primary care provider (PCP), or were identified through acute care. Once a member was identified and enrolled into the care coordination program, Kaiser reported that the member received ongoing support, resources, and communications from their assigned care coordinator.

Within the pediatric care coordination program description, Kaiser outlined how it ensured members received care through standard workflows. Kaiser's program description noted that early identification and treatment for children with special health care needs would significantly improve long-term outcomes. In addition, Kaiser provided an example of one case wherein the member's needs had changed, and the member needed additional support. Through close coordination with the member's family and early identification of the need, the additional support and resources had improved the member's and the member's family situation significantly.

The policy describing transitions to other care and the interview session with staff members detailed how members were transitioned between different healthcare settings. During discussions with staff members and as stated in the policy, members discharged from an inpatient setting would receive support through the Transition of Care (TOC) Team to assist in obtaining resources needed to ensure the member had the appropriate source of care. Additionally, Kaiser described a process to ensure continuity of care through transitions other than inpatient care settings, such as between managed care plans and child-to-adult transitions.

Recommendations and Opportunities for Improvement

During the interview session, Kaiser reported that although member outreach was conducted once a member was enrolled into the plan, reaching the member to complete the initial assessment was challenging. Kaiser's submitted documentation described how Kaiser conducted two phone outreach attempts and sent a letter to the member if the phone outreach was unsuccessful. Kaiser reported it would continue to periodically outreach the member if the member had not been outreached "in a while." HSAG strongly encourages Kaiser to consider additional interventions to improve initial assessment completion rates.

In regard to the new requirement, Kaiser reported that when a pregnant member was identified, the member would undergo an evidence-based risk assessment to get the member the appropriate care expeditiously. HSAG recommends that Kaiser develop a method to monitor the time frame for outreaching the pregnant member within seven business days of identifying a high-risk pregnancy, to ensure Kaiser meets the timeliness requirement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

Kaiser staff members reported providing members with information pertaining to their rights and responsibilities through the CHP+ member handbook. Members were provided access through the website at any time and could receive a free copy upon request. The CHP+ member handbook listed the rights and responsibilities that are required in accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.100. In addition, during the interview, Kaiser noted that staff members and providers were trained on member rights to ensure they could assist CHP+ members with their rights and responsibilities. Kaiser provided a member rights policy that its staff members and providers could regularly access.

The Non-Discrimination in the Provision of Healthcare policy described how Kaiser is not to discriminate against individuals including patients, members, or visitors based on race, color, religion, sex, gender identity, sex stereotyping, sexual orientation, national origin, age, physical or mental disability, veteran status, or other basis that is protected by federal, State, or local law. The policy also noted the grievance procedure that referenced providing prompt resolutions to any complaints based on allegations of discrimination. Kaiser staff members confirmed during the review that any reported member rights issue would be investigated and resolved sufficiently.

Kaiser submitted multiple documents that described how Kaiser ensured the confidentiality of protected health information (PHI) when creating, maintaining, and sharing information. The Information Security and Privacy Incident Management policy included a process to identify, investigate, document, and report security and privacy incidents. Kaiser staff members reported that any incident reported to Kaiser would be thoroughly investigated and that remediations would be put into place.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

Kaiser submitted extensive credentialing policies, procedures, and well-organized records that aligned with National Committee for Quality Assurance (NCQA) requirements. Credentialing files processed by Kaiser contained required primary source and verification details. Kaiser searched State and federal listings to ensure that the practitioners and organizations were in good standing prior to credentialing and recredentialing. Kaiser also described its Delegated Credentialing Program, wherein it delegated some credentialing to University Physicians, Inc. (UPI), Dispatch Health, and Colorado Permanente Medical Group. Kaiser provided its Delegation Oversight policy as well as delegated agreements which outlined responsibilities, reporting requirements, and oversight. During the interview, staff members described annual monitoring for all delegated credentialing activities.

Kaiser submitted written policies and procedures that described the types of practitioners it credentials. Kaiser's Provider Requirement and Retention Plan described retention strategies such as new provider orientation and onboarding, annual and ongoing training, recognition programs, leadership development, and engagement surveys. Practitioners were informed of their credentialing rights through their Colorado Health Care Professional Credentials Application.

During the interview, staff members described Kaiser's systematic credentialing process, which included extensive application review and verification by the Credentialing Department prior to Credentials and Privileges (C&P) Committee approval. Clean applications were added to a weekly report and forwarded to the C&P Committee co-chair for approval, with final approval occurring at the subsequent committee meeting. Applications with identified issues were added to the committee agenda for review and discussion. Credentialing Department staff members described various databases to track and maintain up-to-date information, including system controls to identify expirations and record renewals.

Kaiser's C&P Committee membership consisted of a designated medical director, physicians, and non-physicians. The C&P Committee maintained ultimate responsibility and oversight of credentialing decisions. To ensure credentialing was conducted in a nondiscriminatory manner, all credentialing files were processed using identical non-discriminatory criteria, and an annual non-discrimination report was processed and reviewed by the C&P Committee. Further, all C&P Committee members completed initial and annual non-discrimination declarations.

HSAG reviewed a sample of initial credentialing files and found that Kaiser processed all records in a timely manner. Each provider credentialing file included evidence of license verification, verification of education and training, and verification of work history in the most recent five years; professional

liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years; and Drug Enforcement Administration (DEA) verification, if applicable. HSAG also reviewed a sample of recredentialing files and found that Kaiser appropriately recredentialed providers within the 36-month time frame. Further, Kaiser provided evidence that it conducted ongoing monitoring of providers through its contract with the National Practitioner Data Bank (NPDB) for continuous query monitoring, which produced monthly reports that were reviewed by the Credentialing Department and passed onto the C&P Committee for review if findings were significant.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

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 Title 42 of the Code of Federal Regulations 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 December 2020, February 2023, and May 2024. The Department of Health Care Policy & Financing (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 has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), HSAG.

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) 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 compliance review activities for Kaiser. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 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 credentialing and recredentialing record reviews. Appendix C lists the HSAG, CHP+ MCO, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2024–2025 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*, February 2023.[1] Appendix F contains details of care coordination special focus topic discussions that took place during the virtual compliance review.

[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*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 19, 2024.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for the three chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing.

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the three standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the CHP+ MCOs' contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. 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 CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

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*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The three standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

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 three 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, timeliness, and accessibility of 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.

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 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 the CHP+ MCO until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, Kaiser was required to complete three required actions:

- Revise the provider directory PDF and the new member postcard to describe how the member can request auxiliary aids and services.
- Update the desktop procedure, literature report procedure, and "how to order literature" process to be consistent with the time frame in the requirement.
- Develop a process to conduct outreach or other forms of communication with the provider to ensure the information on the website's provider directory is up to date and accurate.

Related to Standard VII—Provider Selection and Program Integrity, HSAG found no required actions for this standard.

Related to Standard IX—Subcontractual Relationships and Delegation, Kaiser was required to complete one required action:

- Update the agreement between Kaiser and UPI to include the required language and submit an approved amendment.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, HSAG found no required actions for this standard.

Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in March 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to Kaiser. Kaiser submitted final documentation and completed the CAP in July 2024.

Summary of Continued Required Actions

Kaiser successfully completed the FY 2023–2024 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3	1. Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. Informed Consent 4. 2024 Quality Program Description_Final for QOC 5. Clinical Criteria for UM Decisions 7.2024 6. Authorization of Service Policy 04.30.24 7. Colorado Continuity of Care Guidelines and Handling 8. One-Sheet_PMIC_FINAL 9. Pediatric Care Coordination Program Description 2024 10. Care Coordination Playbook_2024 11. PHM101_AB_KPCO Population Health Management Program Description_2024_Final_MOCK 12. Well Child 2 month template 10-2024 13. Well Child 9-10 year templates 10-2024 14. KPCO Peds Developmental Screening Workflows 15. Member Resources – Charitable Health Government Programs | Kaiser Permanente Colorado Options 16. Lippincott Procedures - Population Management and Integrated Care RN	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Adult Care Coordination Outreach_Adult Complex Care Coordination 17. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach, Pediatric Care Coordination 18. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach_Adult Integrated Care Coordination	
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—10.5.3.1	1. Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. 2024 Quality Program Description_Final for QOC 4. CHP EOC Postcard_6200402-13724-POSTCA_9900-1up-POSTCA-001 5. New Member Postcard_1293356290_2024-Co-Chp-Self-Mailer_CHC_CO-DB_2024 6. CB NM (ID Card) 7. CHP-plus-newmember-guidebook-co-en.pdf, page 15 8. PC Continuity Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B—10.5.3.2.1, 10.5.3.2.1.1–2, 10.5.3.2.1.4	1. 2024 Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. Authorization of Service Policy 04.30.24 4. 2024 Quality Program Description_Final for QOC 5. Transitions of Care (B1) 6. Hospital Admission Authorization and Concurrent Review 7. KPCO_Provider_Manual_Section_3_Member_Eligibility_Benefit 8. Pediatric Care Coordination Program Description 2024 9. Colorado Continuity of Care Guidelines and Handling	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities.	1. Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. One-Sheet_PMIC_FINAL (B1,2) 4. Care Coordination Playbook_2024 5. Pediatric Care Coordination Program Description 2024 6. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach, Pediatric Care Coordination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(3) Contract: Exhibit B—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4		
5. The Contractor shall complete an evidence-based risk assessment for all pregnant members (unless member declines or is unable to be reached) within seven business days of identifying a pregnant member. • Contractor must conduct outreach to initiate service coordination activities within seven business days of designating a high-risk pregnancy. Contract: Exhibit B— 10.1.6.1, 10.1.6.2	1. New Pregnancy Intake	*Information Only*
6. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.4.1.3	1. 2024 Quality Program Description_Final for QOC 2. One-Sheet_PMIC_FINAL (B1,2) 3. Pediatric Care Coordination Program Description 2024 4. Care Coordination Playbook_2024 5. Lippincott Procedures - Population Management and Integrated Care RN Adult Care Coordination Outreach_Adult Complex Care Coordination 6. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach, Pediatric Care Coordination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach_Adult Integrated Care Coordination 8. PHM101_AB_KPCO PHM Program Description_2024_Final_MOCK	
7. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—10.5.6	1. 2024 Quality Program Description_Final for QOC 2. KPCO_Provider_Manual_Section_8_Quality_Assurance_ and_Improvement, page 15 8.10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.5.9, 13.1.2	1. KPCO_Provider_Manual_Section_9_Compliance 2. KPCO-Provider-Manual-Section-7-Member-Rights 3. Code of Ethical Conduct - Kaiser Permanente's Principles of Responsibility (9245_0)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.5.9.1.1	1. Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. CHP EOC Final ENG 7.1.2024_ADA 4. One-Sheet_PMIC_FINAL (B1,2) 5. Pediatric Care Coordination Program Description 2024 6. Care Coordination Playbook_2024 7. Lippincott Procedures - Population Management and Integrated Care RN Adult Care Coordination Outreach_Adult Complex Care Coordination 8. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach, Pediatric Care Coordination 9. Lippincott Procedures - Population Management and Integrated Care RN Pediatric Care Coordination Outreach_Adult Integrated Care Coordination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be:	1. 2024 Quality Program Description_Final for QOC 2. Clinical Criteria for UM Decisions 7.2024 page 1 (B2) 3. One-Sheet_PMIC_FINAL (B1,2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to prior-authorization requests). • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.9.1.2-3	4. Pediatric Care Coordination Program Description 2024 5. Care Coordination Playbook_2024 6. PHM101_AB_KPCO Population Health Management Program Description_2024_Final_MOCK	
11. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.9.1.4	1. Outbound DLP Final 1.0 2. 2024 1508 Process DLP Final 1.0 3. Authorization of Service Policy 04.30.24 4. CHP EOC Final ENG 7.1.2024_ADA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	1
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
			Total Score ÷ Total Applicable			=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—7.3.6.1	1. CHP Member Rights Policy 2. CHP EOC Final ENG 7.1.2024_ADA 3. kpco-provider-manual-section-7-member-rights-en	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., nondiscrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B—15.10.9.2	1. kpco-provider-manual-section-7-member-rights-en 2. kpco_provider_manual-section-9-compliance-en 3. Nondiscrimination in the Provision of Healthcare 4. CHP Member Rights Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment.	1. CHP Member Rights Policy 2. CHP EOC Final ENG 7.1.2024_ADA 3. kpco-provider-manual-section-7-member-rights-en	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—7.3.6.2-6		
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—7.3.6.3.7	1. CHP Member Rights Policy 2. CHP EOC Final ENG 7.1.2024_ADA 3. kpco-provider-manual-section-7-member-rights-en 4. Internal Reporting of Ethics and Compliance Concerns	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224*	1. kpco-provider-manual-section-7-member-rights-en 2. CHP EOC Final ENG 7.1.2024_ADA 3. Information Security Governance and Organization 4. kpco_provider_manual_section-9-compliance-en	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—10.5.5.9, 13.1.2	5. Access to PHI by Members and Patients 6. Acceptable Use of KP Information Systems and Assets	

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B—9.2.3, 9.2.3.1	1. CO.CRED.001 Credentialing Policy 2. NCQA Accreditation exp 12.16.2024	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	1. CO.CRED.001 APP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.*	1. CO.CRED.001 Credentialing Policy 2. Annual Non-Discrimination Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(c) NCQA CR1—Element A6		
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element A10		
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	1. CO.NDPC.002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	1. CO.CRED.001 Credentialing Policy 2. Colorado Healthcare Credentials Application	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	1. Credentials & Privileges Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	1. CO.CRED.001 Credentialing Policy 2. Credentials & Privileges Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if	1. CO.CRED.001 APP 2. Colorado Healthcare Credentials Application	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.*		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	1. CO.CRED.001 APP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	1. CO.CRED.001 APP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	1. CO.CRED.001 Credentialing Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A	1. CO.CRED.001 MON (#s 1-3) 2. Potential Quality of Care Concerns and Peer Review Events Procedure_CO.DSQ.002 3. CO.CRED.004 (#s 4-5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners.	1. CO.CRED.004 (#1) 2. CO.CRED.003 (#2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities. NCQA CR6—Element A		
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1	1. CO.CRED.002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	1. CO.CRED.002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	1. CO.CRED.002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and processes include: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7—Elements B and C	1. CO.CRED.002	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses providers every 36 months. NCQA HP CR7—Elements D and E	1. CO.CRED.002 2. CR7 D&E Reports (Combined with CO.CRED.002)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity.	1. CO.QUAL.7204-22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	N/A - No new delegation agreements were in effect for less than 12 months	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C	1. CO.QUAL.7204-22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	1. CO.QUAL.7204-22	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Kaiser Permanente

Review Period:	1/1/2024 – 12/31/2024
Completed By:	Cindy Freeman, Tanya Holden, and Jenn Bond
Date of Review:	12/4/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Cindy Freeman

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	REMOVED	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	MD	OD	PA-C	NP	DNP	DO	NP	DPT		DPT	PT
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Dermatology	Optometry	PA-C	NP	Family Medicine	Family Medicine	NP	PT		DPT	PT
Date of Completed Application [MM/DD/YYYY]	1/29/2024	2/20/2024	2/29/2024	2/29/2024	3/15/2024	4/12/2024	4/25/2024	5/18/2024		7/18/2024	7/15/2024
Date of Initial Credentialing [MM/DD/YYYY]	2/9/2024	2/23/2024	3/8/2024	3/22/2024	4/5/2024	4/19/2024	5/3/2024	5/24/2024		8/2/2024	7/19/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence of Board Certification Yes, No, NA	Yes	NA	Yes	NA	NA	Yes	NA	NA		NA	NA
Evidence of Board Certification Met? [VIII.6]	Met	NA	Met	NA	NA	Met	NA	NA		NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA		NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	NA		NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met		Met	Met

Comments:
File 9: HSAG removed this file from the sample as Kaiser explained that credentialing was started but not completed due to a lack of provider response. File 9 was replaced with File OS1.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Kaiser Permanente

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Applicable Elements	9	8	9	8	8	9	8	7		7	7
Compliant (Met) Elements	9	8	9	8	8	9	8	7		7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%
Total Applicable Elements	80										
Total Compliant Elements	80										
Total Percent Compliant	100%										

Notes:

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

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Kaiser Permanente

Review Period:	1/1/2024 – 12/31/2024
Completed By:	Cindy Freeman, Tanya Holden, and Jenn Bond
Date of Review:	12/4/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Cindy Freeman

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Provider ID #	REMOVED	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)		DO	PT	PA	MD	NP	MD	MD	DPT	LCSW	L.Ac
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)		Pathology	PT	Dermatology	Internal Medicine	Nephrology	Ophthalmology	Orthopaedic Surgery	PT	Social Worker	Acupuncturist
Date of Last Credentialing [MM/DD/YYYY]		6/28/2021	6/11/2021	4/16/2021	8/13/2021	9/24/2021	8/20/2021	6/25/2021	7/23/2021	8/2/2021	2/25/2021
Date of Recredentialing [MM/DD/YYYY]		2/16/2024	3/1/2024	3/15/2024	3/29/2024	4/26/2024	5/3/2024	5/24/2024	6/28/2024	7/26/2024	1/12/2024
Months From Initial Credentialing to Recredentialing		31	32	34	31	31	32	34	35	35	34
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)		Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]		Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA		Yes	NA	NA	Yes	NA	Yes	Yes	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]		Met	NA	NA	Met	Met	Met	Met	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA		NA	NA	Yes	Yes	Yes	Yes	Yes	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]		NA	NA	Met	Met	Met	Met	Met	NA	NA	NA
Evidence of Malpractice History Yes, No, NA		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]		Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]		Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]		Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
File 1: HSAG removed this file from the sample as it was not a recredentialing file. File 1 was replaced with File OS1.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Kaiser Permanente

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Total Applicable Elements		6	5	6	7	7	7	7	5	5	5
Total Compliant (Met) Elements		6	5	6	7	7	7	7	5	5	5
Total Percent Compliant		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	60										
Total Compliant Elements	60										
Total Percent Compliant	100%										

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation
9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of Kaiser.

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
Kaiser Participants	**Title**
Liz Chapman	Medicaid Contract Compliance Manager
Kristen Swart	Medicaid Health Plan Compliance Consultant
Casey Snow	Accreditation, Regulatory, and Licensing Specialist
Jenn Bond	Credentialing Medical Office Specialist
Kathleen Westcoat	Senior Director, Claims Operations
Romilee Perdon	Medicaid Health Plan Compliance Consultant
Vanessa McDonald	Medicaid Health Plan Compliance Consultant
Cindy Freeman	Credentialing Medical Office Specialist
Tanya Holden	Credentialing Medical Office Specialist
Dorothy Chan	Privacy, Security, and Technology Compliance
Elizabeth Bradley	Group Relations Project Manager III
Trey Parks	Medicaid Health Plan Compliance Consultant
Jason Connell	Senior Director of Regional Compliance
Amy Archer	Utilization Management Medical Audit Coordinator
Brady Van Dyke	Director of Population Health
Carlos Madrid	Health Plan Community Health Consultant
Chanda Moellenberg	Population Health Program Manager
Chea Sanchez	Supervisor, Credentialing Medical Office
Derrick Washington	Health Plan Administration Regional Director
Erica Anderson	Senior Director of Operations
Dr. Lauren Galpin	Medical Director of Medicaid and Charitable Programs
Robin Beagle	Director of Accreditation, Regulatory, and Licensing
Scott Campbell	Manager of Customer Experience Operations
Heidi Lorenz	Senior Director of Population Health
Layne Montoya	Population Health Clinical Consultant
Roxane England	Accreditation, Regulatory, and Licensing Specialist
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Jerry Ware	Contract Administrator

Appendix D. Corrective Action Plan Template for FY 2024–2025

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—CAP Process

Step	Action
Step 1	**CAPs 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.	

HSAG identified no required actions; therefore, the CAP template is not included.

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*, February 2023.

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, 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 three 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, credentialing, recredentialing, and organizational provider credentialing record review tool, sample records, policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and applicable documents to support the special focus topic. • 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.

For this step,	HSAG completed the following activities:
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 Department-approved FY 2024–2025 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.

Care Coordination

The purpose of the CHP+ Special Focus Topic: Care Coordination interview was to explore the trends, strengths, and challenges that each Colorado CHP+ plan has experienced with the evolution of its care coordination program. A sample of topics covered in each CHP+ discussion included the rate of completion for initial screenings, specifically among members with high-risk pregnancies; addressing health-related social needs (HRSN) and equity; describing successful partnerships and barriers; coordinating chronic disease management; and handoff processes for transitions of care. For the interview, Kaiser prepared a few slides to cover the topic areas and provided data and anecdotal information to describe features of its care coordination program and how the program aims to meet members' healthcare needs at various levels.

Well-Child Visits and Screening

Kaiser implemented a comprehensive approach to well-child visits, beginning with a postpartum home visit within three days of birth. This visit included assessments of both mother and baby, including weight, blood pressure, bilirubin levels, mood, and a review of the household environment (e.g., pets, smokers, other children). This information was documented in preparation for the subsequent two-week appointment. Kaiser reported that a "vast majority" of newborns who arrived in office for the two-week well-child visit had reported having this three-day home visit.

HSAG inquired about interventions for families with specific needs. In cases wherein smoking was identified in the home, Kaiser provided education and resources, including information on nurse-family partnerships and community groups. For families facing HRSN challenges such as food insecurity or inadequate housing, Kaiser conducted a social health screening. This screening, available to providers with access to Health Connect, assessed the level of risk. Members were provided with a checklist to identify their needs (e.g., food, utilities, loneliness, transport) and preferred method of support (e.g., self-search, help center, outreach). If outreach was requested, the member's chart was automatically routed to a community resource specialist.

Postpartum depression screening was conducted at two and six weeks. Follow-up was provided based on the screening results. While screening was not routinely performed after six weeks, HSAG recommended continued check-ins, particularly with lower-income families. Kaiser noted that adult members received routine depression screenings during their well visits.

For the teen population, Kaiser provided information on gun safety and offered gun safety locks. Kaiser also emphasized confidentiality for teen patients and conducted Patient Health Questionnaire (PHQ)-2 screenings for teens ages 11 and 12 years.

Chronic Disease Management

Kaiser implemented registries to track children with asthma and attention-deficit/hyperactivity disorder (ADHD). Support coordinators reviewed these lists to determine necessary follow-up, which may have included referrals to complex care nurses or the allergy department. This process was integrated into their workflow. For children with ADHD, support coordinators ensured follow-up appointments were scheduled.

Risk Stratification

Kaiser employed risk stratification tools to identify members requiring care coordination. Recognizing issues with excessive false positives from the existing tool, Kaiser's analyst team developed a new tool to target outreach efforts more accurately. This new tool was currently undergoing refinement and validation through comparisons with past history and algorithm-based scoring.

HSAG inquired about equity considerations in the risk stratification process. Kaiser acknowledged that engagement was a key challenge, particularly with members who saw other providers. Kaiser was actively working to assess the impact of racial and socioeconomic factors on engagement and identify any missed populations. While data were not yet formally documented, Kaiser's equity committee tracked screener responses across different populations. They noted that non-English speakers were the most challenging group to engage.

Kaiser reported that switching from phone-based screening to online forms significantly increased responses, suggesting greater comfort with private online communication. Kaiser also collected patient feedback grouped according to racial groups to understand how different populations connected with providers. Kaiser strove to maintain a diverse provider population and offered cultural competence training for staff and the public.

Transition of Care

Kaiser described its process for transitioning members from pediatric to adult care, using the example of a patient with cerebral palsy moving to the adult complex program. The pediatric and adult complex care coordinators collaborated to ensure continuity of services. The patient was connected with a primary care provider and monitored by the adult complex care coordinator.

A dedicated committee worked to improve the transition process. The transition period began before the patient turned 18 years of age, allowing teens to access specialty providers. Young adult welcome flyers were distributed for each specialty, providing information on appointments and other frequently asked questions. For patients with two or more ongoing specialty needs, complex care nurse coordinators used a comprehensive checklist with pediatric nurses. A general health skills checklist was administered in early and late teen years to support families through the transition. Kaiser also highlighted the valuable

perspective of a neurodiverse patient on its pediatric advisory council, which led to improvements in Kaiser's questionnaires.

Finally, Kaiser shared an example of a patient transitioning between pediatric and adult pulmonologists, with the physicians collaborating to ensure a smooth transition.

HSAG identified the following strengths related to care coordination:

- The postpartum home visit within three days of birth exhibits a commitment to early intervention and allows for early identification of potential issues for both mother and baby.
- The use of registries and dedicated support coordinators for children with asthma and ADHD demonstrates a structured approach to chronic disease management.
- Kaiser's use of data to track outcomes, identify trends, and refine its risk stratification tools demonstrates a commitment to continuous improvement.

HSAG identified the following opportunities related to care coordination:

- Strengthen data collection and analysis efforts to better track outcomes, identify trends, and monitor the effectiveness of interventions. This includes data related to HRSN, engagement, and transition of care.
- Continue to provide cultural competency training for staff and ensure that resources and services are culturally and linguistically appropriate for the diverse populations served.
- Engage patients and families in the design and evaluation of care coordination and transition processes to ensure that their needs and preferences are being met.
- Continue to identify and implement strategies to improve the rate of administering health assessments to new members and members who have not been assessed recently or ever.