COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Accountable Care Collaborative: Access Kaiser Permanente (ACC: Access KP)

May 2017

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

Colorado Revised Statutes 2013, 25.5-1-101—"State Health Care Policy and Financing Act"—provided the authority for the Department of Health Care Policy & Financing (the Department) to enter into a contract with Colorado Access for implementation of a Medicaid payment reform pilot program using a partial-benefit, full-risk, value-based capitation structure. The purpose of the pilot program was to learn the efficacy of this alternate Medicaid payment methodology in terms of total cost of care and the effect on health outcomes for members. Colorado Access' contract with the Department allowed Colorado Access to subcontract any portion of the pilot program contract to Kaiser Foundation Health Plan of Colorado. Colorado Access' contract with the Department required Colorado Access to comply with federal Medicaid managed care regulations at 42 CFR 438 et seq. The Balanced Budget Act of 1997 (BBA), Public Law 105-33, with revisions published May 2016, requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) to determine compliance with federal healthcare regulations and contractual requirements. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

The payment reform contract between Colorado Access and the Department was effective July 2016. Fiscal year (FY) 2016–2017 represents the initial year of HSAG compliance reviews for the Colorado Access pilot program, **Accountable Care Collaborative (ACC): Access Kaiser Permanente** (**Access KP**). This report documents results of the FY 2016–2017 site review activities for the review period of July 2016 through March 2017. **Access KP** site review activities consisted of review for compliance with federal Medicaid managed care regulations and State contract requirements. For each of the three 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 2016–2017 compliance monitoring site review. Appendix A contains the compliance monitoring tool used for the review of standards. Appendix B contains details of the findings for Medicaid member services and claims denials record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2016–2017 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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 within the compliance monitoring tool 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. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations.

Table 1-1 presents the scores for **Access KP** for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	38	34	24	8	2	4	71%
II. Access and Availability	15	13	11	1	1	2	85%
IX. Subcontracts and Delegation	11	11	6	3	2	0	55%
Totals	**64**	**58**	**41**	**12**	**5**	**6**	**71%**

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

Table 1-2 presents the scores for **Access KP** for the denials record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	56	4	40	93%
Totals	**100**	**60**	**56**	**4**	**40**	**93%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

Covered services of the **Access KP** contract are limited to 2,100 ambulatory primary and specialty care codes. All covered services must be provided within the Kaiser Permanente (KP) network. All other services needed by members are provided through Medicaid fee-for-service (FFS). Colorado Access delegated all **Access KP** utilization management (UM) activities to KP. KP's Resource Stewardship Utilization Management program and UM policies and procedures and processes ensure that KP delivers services sufficient in amount, duration, and scope. KP's UM authorization processes, applied to **Access KP** contracted services only, demonstrated that KP applies several sources of medical necessity criteria in UM decision making; UM determinations are made by qualified clinicians; requesting providers are consulted when necessary; and members and providers are notified in writing of UM decisions. KP conducts annual interrater reliability monitoring of staff and physician reviewers. UM policies addressed procedures for authorization of services and timelines for UM decision making and notification. Notices of action (NOAs) to members and providers included all required information.

Although **Access KP** is generally liable for only professional services associated with an emergency condition (the facility fee is the responsibility of Medicaid FFS), staff members stated that KP performs no UM review of emergency room (ER) claims and no ER claim is denied for any reason. Post-stabilization services are the responsibility of the Medicaid FFS program.

On-site denial record reviews confirmed the following:

- All 10 cases involved a new request for services; five were standard pre-service requests, three were expedited pre-service requests, two were retrospective requests.
- No cases included an extension of the decision time frame.
- HSAG found that in all 10 cases the authorization decision was based on established criteria and made by a qualified clinician, an NOA was sent to the member and provider, and the NOA included required content.

Summary of Findings Resulting in Opportunities for Improvement

On-site denial record reviews identified the following opportunities for improvement:

- Seven of 10 cases were denied due to requests for out-of-network services (**Access KP** members are required to receive covered services within the KP network). Two of 10 cases were denied retrospectively because the provider assumed that the member was traditional Medicaid and failed to request pre-service authorization from **Access KP**. These findings may indicate that some members and providers remain confused about the unique requirements of the **Access KP** program. HSAG recommends that Colorado Access and KP consider clarifying communications to members and

providers to reinforce both the requirement that KP members receive services in network and the need for providers to confirm **Access KP** membership prior to providing services.

- HSAG observed that some information in the NOA, such as advising the member that an alternative is for the member to pay for the requested service personally or through other insurance, may be inappropriate for Medicaid members. HSAG recommends that KP revise its NOA for Medicaid members to more clearly explain that the alternative for an out-of-network denial is to obtain the service within the KP network.
- The NOA appeal template included some information that was either irrelevant—for example, "determine which one of the adverse benefit determination notices listed below you received by reading the "Claim Type" indicated on the first page of your notice: Post-Service Claim Denial Notice; Pre-Service Claim Denial Notice; Concurrent Care Claim Denial Notice," or was written in language not easy to understand. HSAG recommends that KP review and revise the template *Your Appeal Rights* to simplify the information provided and ensure ease of understanding (at or near the sixth-grade reading level) for Medicaid members.
- HSAG noted that the template NOA letter includes many drop-down boxes and free-form text fields that could result in correspondence to members that is difficult to understand. HSAG recommends that KP consider assigning an individual to perform manual review of each **Access KP** letter prior to mailing to ensure that it includes language and information appropriate for a Medicaid member.

KP's UM policies and procedures for processing authorization requests were inclusive of all lines of KP business and sometimes failed to clearly distinguish the requirements applicable to **Access KP**. HSAG also observed several inconsistencies or gaps in policies that could contribute to confusion for UM reviewers. Specific examples include:

- The Timeliness of UM Decision-Making and Notification policy addresses outreach to the requesting provider to obtain more information only when related to urgent pre-service requests. In addition, the policy addresses time frames for expedited authorization decisions, but only related to CHP+, not to **Access KP**.
- The Denial of Coverage policy addresses consulting with the requesting physician when necessary, but only related to members of Medicare or commercial contracts. Similarly, the policy defines the content of the NOA, but only related to CHP+, not to **Access KP**.

HSAG recommends that KP carefully review and update its UM policies and procedures to ensure that requirements applicable to **Access KP** are clearly and accurately delineated.

Summary of Findings Resulting in Required Actions

The KP Medical Necessity Criteria policy outlined numerous sources of medical necessity criteria used in making UM decisions. The Authorization of Services policy stated that KP ensures that benefits are no more restrictive than defined in "state statutes and regulations and the State Plan." However, KP policies and procedures did not outline the specific medical necessity criteria applicable to Medicaid members or refer staff members to another source to obtain these criteria. Colorado Access must ensure

that KP updates its UM policies and procedures applicable to **Access KP** authorization decisions to clearly define the medical necessity criteria outlined in the State plan. HSAG recommends that KP use the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—to update its policies and procedures.

The Timeliness of UM Decision-Making and Notification policy specified that the timeline for standard authorization decisions was 10 calendar days for **Access KP** members. However, HSAG identified in denial record reviews that three of 10 records included notices of action not compliant with this time frame. Colorado Access must ensure that KP provides NOAs to members for standard authorization decisions within 10 calendar days from receipt of the request for service.

HSAG noted in on-site denial record reviews that some template language included in the NOA did not ensure ease of understanding or approach sixth grade reading level. In addition, HSAG identified one record in which the free-form text explanation of the reason for denial was highly technical. Colorado Access must ensure that KP's NOAs to **Access KP** members are written in language and format which ensure ease of understanding for the member (i.e., sixth grade reading level where possible).

KP's Timeliness of UM Decision-Making and Notification policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. Staff members stated that KP does not terminate or reduce previously approved authorizations for members. However, the policy omitted reference to other notification time frame requirements applicable to Medicaid members, specifically:

- For service authorization decisions not reached within the required time frames on the date the time frame expires.
- If the Contractor extends the time frame, no later than the date the extension expires.
- For denial of payment, at the time of any action affecting the claim.

In addition, staff members were unable to confirm whether or not claims payment procedures were aligned with the requirement to provide an NOA to the member at the time of any action affecting the claim (i.e., denial of payment decisions). Colorado Access must ensure that KP updates its policies and procedures to address all notification time frames applicable to **Access KP** members as outlined in the requirement. Colorado Access must also confirm that KP's claims payment procedures are aligned with the requirement to provide an NOA to the member at the time of denial of claim payment (excludes administrative denials).

KP did not have policies and procedures to address Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Staff members stated that some operational processes were in place within the KP network to ensure provision of EPSDT services and that KP has implemented the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. Staff members also stated that KP intended to develop written EPSDT policies and procedures to address comprehensive EPSDT requirements based on results of the on-site audit. Colorado Access must ensure that KP develops and implements written policies and procedures related to comprehensive EPSDT services and requirements for members ages 20 and under. KP must address in its policies, procedures, and operational processes:

- Mechanisms used by KP to implement the AAP Bright Futures periodicity schedule.
- Provision of all required components of periodic health screens (as outlined in Element #34 of the compliance monitoring tool).
- Provision of diagnostic and treatment services needed as a result of EPSDT screening (including vision services, dental services, and immunizations), even if services are not covered under the **Access KP** plan.
- Requirements and provider expectations related to referrals and authorizations for EPSDT-related care in or out of network.
- Assurance that EPSDT beneficiaries may self-refer for routine vision, dental, hearing, or mental health services; or for family planning services.
- The definition of "medical necessity" for EPSDT services as outlined in the State Medicaid Plan (10 CCR 2505-10 8.076.1.8 and 8.076.1.8.1) and application of EPSDT-specific criteria in UM decisions.
- Mechanisms for systematic—i.e., regular and periodic—communications with network providers regarding the Department's EPSDT requirements.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access delegated provision of primary care and specialty services for **Access KP** members to KP. KP documented having an extensive network of primary care and specialist providers available to serve all KP members in the **Access KP** service area. Per design of the **Access KP** pilot program, **Access KP** members were previously receiving services from KP at the initiation of the contract, and no increase in **Access KP** membership was anticipated. **Access KP**'s approximately 22,700 members represented only a small portion of the total KP membership in the service area. Staff stated that all **Access KP** covered services can be provided in network. KP's Network Adequacy analysis documented numbers, types, and geographic locations of primary care and specialist providers in excess of contract requirements. KP eliminated from the analysis those providers with full practices. KP conducts quarterly monitoring of practitioner panel status and appointment availability in order to determine any stress on provider network availability and responds to any potential capacity issues through recruitment or relocation of providers as necessary.

KP provided female members with direct access to obstetrics/gynecology (OB/GYN) practitioners and provided for second opinions in network. Although by design all covered services can be provided within the KP network, KP arranged for covered services out of network if services could not be provided in network. Staff stated that when the member needs services not covered by the **Access KP** contract—i.e., Medicaid FFS—providers continue to clinically manage the member, make necessary referrals, and bill FFS as applicable. KP's appointment scheduling guidelines for all members were more stringent than those defined in the **Access KP** contract, and were monitored quarterly. The KP network

includes a variety of individual and group providers qualified to provide EPSDT services. The Health First Colorado member handbook informs members of the availability of EPSDT services.

KP demonstrated that it had a multifaceted national diversity policy and implemented local procedures to promote cultural competency among providers and staff. KP provided live workshops and seminars and webinar trainings covering a variety of cultural diversity topics, and required staff and providers to participate in annual cultural diversity training. KP offers verbal and written translation for member communications in numerous languages. Staff stated that KP has, in an effort to provide culturally sensitive services beyond language translation, integrated personnel representing various ethnic groups into medical offices which serve high-volume ethnic populations.

Summary of Findings Resulting in Opportunities for Improvement

Access KP used several member handbooks as sources of information to members. HSAG observed that information in these member communications, specifically in the *Access KP Guide* and *Denver/Boulder Member Resource Guide*, included some information that was either inaccurate or inconsistent as follows:

- The *Denver/Boulder Member Resource Guide* (available to all KP members) informed members that they may see an OB/GYN physician for routine care while maintaining a primary care provider (PCP) for other needs. However, another section of the guide lists OB/GYN practitioners as specialists and states "Medicaid members require a referral to see a specialist." These two statements appear to be in conflict and should be clarified to communicate that Medicaid members do need a referral to see a women's health specialist.
- The *Denver/Boulder Member Resource Guide* stated that KP members may obtain a second opinion from a Kaiser physician and may consult with a non-plan physician "at your own expense." This is inaccurate for Medicaid members, who may obtain a second opinion outside the network if there is no other qualified healthcare professional within the network, at no cost to the member. KP should clarify this statement for Medicaid members.
- The **Access KP** Guide stated that a referral was required for members to obtain out-of-network services, but failed to clearly inform the member that if services are not available in network, KP will provide an out-of-network referral. HSAG recommends that KP consider enhancing this communication to comply with the related requirement for referral to out-of-network services, as specified in Element #6 of the compliance monitoring tool.
- The **Access KP** Guide lists 30 days as the appointment time frame for all types of services except urgent care. This information is out of compliance with scheduling requirements of the **Access KP** contract as well as with KP's own scheduling standards. KP should revise the **Access KP** Guide to be in compliance with the scheduling standards of the contract.

Summary of Findings Resulting in Required Actions

The KP integrated provider system and additional availability of numerous types of specialists within the external contracted network appear to provide sufficient ongoing access to specialists for members with special healthcare needs. However, **Access KP** members are required to have a referral to see a specialist. Colorado Access must ensure that KP referral or UM policies and procedures clearly specify that persons with special healthcare needs who use specialists frequently are allowed to maintain these types of specialists as PCPs or be allowed direct access or standing referrals to specialists.

Although staff members described general referral policies for all members needing additional diagnosis and treatment, as well as a general overview of KP's pediatric quality assurance program, KP did not have EPSDT-specific policies and procedures to address the requirement that providers either refer members to an appropriate practitioner or to Healthy Communities for further EPSDT-related diagnosis and treatment. KP also did not provide evidence of informing providers of EPSDT-related services available through other entities or of information pertaining to Healthy Communities. Colorado Access must ensure that KP addresses EPSDT diagnosis and treatment referral requirements, educates providers about Healthy Communities, and advises providers of EPSDT services available through other entities.

Standard IX—Subcontracts and Delegation

Summary of Strengths and Findings as Evidence of Compliance

The KP delegation agreement specified that the following functions were delegated to KP: care management, communications, finance, claims payment, data management/information technology, member enrollment, UM, appeals and grievances, network management, and provision of primary and specialty services. Colorado Access specified in both the delegation agreement and contract management plan (CMP) a list of deliverables to assist Colorado Access in oversight of functions delegated to the subcontractor. Colorado Access' CMP defined multiple mechanisms for monitoring KP's performance of delegated functions and included evaluation of deliverables, annual on-site reviews, and a comprehensive delegation audit of "deliverables" to be performed every six months. Colorado Access and KP had a joint operating group that met weekly to discuss the implementation of the structural components of the contract. Colorado Access and KP also jointly participated in the Performance Improvement Advisory Committee (PIAC), designated as the oversight mechanism for outcome measurement goals of the **Access KP** pilot program. Prior to implementation of the contract, the Department performed a readiness review of select elements of the **Access KP** contract that included review of both COA and KP processes. HSAG determined that the readiness review would suffice as a pre-delegation evaluation of the subcontractor's ability to perform delegated activities. The KP delegation agreement addressed all required components, including activities and reporting requirements delegated to the subcontractor, provisions for revocation and sanctions, requirements to comply with applicable federal and State laws, and insurance requirements. Colorado Access had certified that KP is not debarred, suspended, or otherwise excluded by any federal agency; does not employ or contract with illegal aliens; holds members harmless from financial responsibility; and had informed members of

member rights and responsibilities. Colorado Access had developed a deliverable tracking schedule to monitor receipt of deliverables from KP and, at the time of on-site review, reported receipt of multiple deliverable reports from KP. Colorado Access conducted one on-site review in September 2016, which consisted of an encounters/claims validation audit and a medical record review of advance directives, many elements of care coordination, and interpreter services.

Summary of Findings Resulting in Opportunities for Improvement

While the KP delegation agreement broadly stated that KP must comply with federal and State laws, it specified few of the applicable laws by name. HSAG recommends that Colorado Access update the delegation agreement to specify all federal and State laws required in the contract with the Department.

Due to the fact that most functions and requirements of the **Access KP** contract were delegated, it would appear that adequate oversight and monitoring by Colorado Access would require extensive resources. It was not apparent to HSAG which Colorado Access organizational resources were engaged in the oversight and monitoring processes. HSAG recommends that Colorado Access enhance its internal monitoring plan to designate staff responsibilities for monitoring and analysis of the various activities delegated to KP.

The CMP stated that Colorado Access would perform a delegation audit of the detailed contract "deliverables," but it was unclear what Colorado Access intended to address in the audit. HSAG recommends that Colorado Access consider designing the proposed delegation audit to comprehensively address all applicable federal requirements related to the subcontractor's delegated activities.

Summary of Findings Resulting in Required Actions

The KP delegation agreement specified that numerous—if not all—operational requirements of the **Access KP** contract were delegated to KP. The Department's contract with Colorado Access specifies that Colorado Access is accountable for all 42 CFR Part 438 requirements related to these delegated activities. While the CMP outlined multiple mechanisms for monitoring the subcontractor's performance, Colorado Access submitted no documents which provided evidence that it had implemented or intended to implement oversight or audit of KP's operational processes related to 42 CFR Part 438. The federal managed care requirements specified in 42 CFR Part 438 include extensive policy, procedure, and operational process requirements; therefore, Colorado Access must include in its CMP a mechanism to ensure compliance with the requirements of 42 CFR Part 438 appropriate to the service or activities delegated to KP and/or must demonstrate accountability for those processes within Colorado Access operations.

Colorado Access had defined an **Access KP** CMP which stated that Colorado Access would perform oversight of the **Access KP** contract requirements, including monitoring of the subcontractor's delegated responsibilities, through annual on-site visits, regular monitoring of deliverables, and a delegation audit every six months. HSAG's findings related to implementation of ongoing and formal review of the subcontractor's performance to date are as follows:

- The CMP failed to address oversight processes related to every area of responsibility—e.g., UM—delegated to the subcontractor in the KP delegation agreement. In addition, the CMP did not clearly define mechanisms for evaluation of KP's operational processes related to each category of delegated activity to ensure that the contract requirements outlined in Appendix B of the CMP were met.
- Colorado Access had documented receipt of numerous KP deliverable reports. Although staff members stated that Colorado Access reviewed each deliverable report to compare to contract requirements, Colorado Access did not document a qualitative assessment of the reports or any conclusions that may have resulted from such. Therefore, it was not evident how Colorado Access used the deliverable reports for monitoring the subcontractor's performance.
- Colorado Access conducted one on-site review in September 2016, which consisted of an encounters/claims validation (30 records) and a medical record review (seven records) of advance directives, elements of a care coordination plan, and interpreter services. However, Colorado Access provided no evidence of qualitative analysis of findings of the audit nor evidence that KP's operational processes (e.g., policies and procedures, staff interviews) were evaluated, as stated in the CMP.
- At the time of on-site review, the detailed delegation audit outlined in the CMP (due January 2017) had not been designed, conducted, or scheduled. Therefore, Colorado Access could provide no evidence of the components of the delegation audit intended to perform a detailed formal review of the subcontractor's "deliverables."

Colorado Access must:

- Ensure that its oversight and monitoring of the subcontractor include assessment of all areas of responsibility delegated to KP as well as thorough assessment of the detailed contract requirements.
- Document results of all oversight activities and KP deliverables in a manner that reflects analysis of findings and related qualitative conclusions.
- Design and implement the delegation audit (due January 2017) timely, as defined in the CMP.

The KP delegation agreement addressed circumstances related to cure of a breach of contract, and the CMP addressed corrective actions in isolated areas of the document. However, the CMP was unclear regarding expectations for corrective action and related time frames overall. Staff members stated that, with the exception of identified individual member issues, time frames and expectations for corrective actions were negotiable based on other operational priorities of the subcontractor. The minutes of the PIAC reflected no review or oversight of KP deliverables, no audit activities, and no corrective actions implemented to date. Colorado Access provided documentation of one formal KP corrective action, which indicated that KP's corrective actions would be implemented nine to 11 months from the date of Colorado Access' required actions. Colorado Access must review its processes to ensure that the subcontractor's performance is adequately analyzed and that all areas of potential deficiency are assessed and corrective actions implemented in a timely manner. Colorado Access should consider more clearly addressing in its CMP expectations for corrective actions.

The **Access KP** delegation agreement assigned responsibility for all care management activities to KP. Although the agreement did outline care coordination requirements reflective of the **Access KP** contract, it outlined the components of the formal system of care defined in the Colorado Access RCCO contract rather than the requirements specified in the **Access KP** contract. The agreement also failed to include several requirements of the **Access KP** contract, such as requirements for maintaining sufficient staffing to ensure that care coordination requirements are performed, maintaining a toll-free number for members to call related to care coordination issues, and documenting all elements of the formal system of care coordination in the care plan. Colorado Access had obtained and reviewed KP's *Formal System of Care Coordination*, but provided no documentation of Colorado Access' review and assessment of the sufficiency of the *Formal System of Care Coordination*. Discussions during the on-site interview indicated that KP was experiencing difficulty performing responsibilities for care coordination of the full continuum of services for members because the **Access KP** contract is limited to a defined set of ambulatory services delivered within the KP network and all other services are Medicaid FFS. Staff stated that KP does not have access to data related to the FFS elements of the continuum of care (e.g., Statewide Data Analytics Contractor [SDAC] data). Nevertheless, the **Access KP** contract clearly states that care coordination requirements include "ensuring that care coordination is provided for members around all covered services and Medicaid FFS services." Colorado Access conducted an on-site review of seven care coordination records in September 2016, which assessed documentation in the medical record of some, but not all, care coordination requirements. Colorado Access provided no documented analysis of results or conclusions resulting from the audit. In addition, it was unclear whether the audit of the members' records applied to the full continuum of service needs or just to **Access KP** covered services. The on-site audit also included no documented findings related to operational care coordination policies and procedures or interviews with staff, as outlined in the CMP. Colorado Access must enhance assessment of the comprehensive care coordination requirements delegated to the subcontractor to ensure that all care coordination requirements specified in the **Access KP** contract are performed by either KP or Colorado Access or collaboratively. Colorado Access should thoroughly document the analysis of results of its assessment processes and work with KP to address any gaps or challenges in performing comprehensive care coordination requirements.

While KP had policies and procedures for authorization of services, no evidence was provided that Colorado Access had reviewed these policies or assessed UM operational processes to determine whether or not KP was adequately following UM procedures for **Access KP** members. The KP delegation agreement outlined numerous additional requirements related to the subcontractor's UM program; however, at the time of on-site review, Colorado Access had not conducted a review of KP for compliance with those requirements. Colorado Access must implement mechanisms to assess and maintain oversight of KP's UM procedures as well as compliance with additional UM requirements of the KP delegation agreement.

2. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard IX—Subcontracts and Delegation. HSAG evaluated Colorado Access' compliance with federal healthcare regulations and contract requirements of the pilot program through review of the three chosen standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site portion of the review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, Colorado Access' delegation agreement with Kaiser Foundation Health Plan (KFHP) of Colorado, and administrative records related to Medicaid service and claims denials. HSAG documented detailed findings in the compliance monitoring tool for any requirement receiving a *Partially Met or Not Met* score.

To implement the pilot program, Colorado Access chose to delegate administrative services and direct care related to the pilot program contract to KFHP. HSAG reviewed a sample of KFHP's administrative records—10 records with an oversample of 5 records—to evaluate implementation of managed care regulations related to Medicaid service and claims denials and notices of action. Reviewers used standardized monitoring tools to document findings. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid service and claims denials that occurred between July 1, 2016, and February 15, 2017, to the extent available at the time of the site review request. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the

Access KP FY 2016–2017 site review represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Compliance Monitoring Tool
for ACC: Access KP

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit A—3.5.1.1	• **KP Colorado - Charitable Programs Monthly Quality Report (Charitable_Programs_Scorecard_20161231.pdf)** • **2016 Integrated Patient Care Quality Program Description (2016-KP_IPCQ.pdf)** – See Purpose and Goals, pg 10. These reports demonstrate that the Kaiser Permanente Colorado monitors the services provided to all our members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration and scope no less than services provided to Mediciad fee-for service recipients within the same area. *42 CFR 438.210(a)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.5.1.2	Except when required by the Access KP contract, Access KP members receive the same access to services in terms of timeliness, amount, duration and scope as members of other lines of business. • **2016 Program Description – Resource Stewardship / Utilization** Management (2016-KP_IPCQ.pdf) – See Section10—Resource Stewardship/Utilization Management Program, pgs 61-64. • **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06** (TimlinessofUMDecisionMaking16.pdf).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. Utilization management (UM) shall be conducted under the auspices of a qualified clinician. Contract: Exhibit A—3.9.1.6	• **2016 Program Description – Resource Stewardship / Utilization Management (2016-KP_IPCQ.pdf)** – See Section10—Resource Stewardship/Utilization Management Program. See highlighted section on pg 62.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. 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 A—3.5.1.3	• **Medical Necessity Criteria, Policy ID #: 6891-14 (MedicalNecessityCriteria16.pdf).** See Policy Statement – demonstrates the guidelines for utilization management decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.5.2.1.1.	• **Medical Necessity Criteria, Policy ID #: 6891-14 (MedicalNecessityCriteria16.pdf).** See Policy Statement – demonstrates limits based on medical necessity determinations. • **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Policy Statement, paragraph 2 and highlighted section on pg 3 – demonstrates review for medical necessity.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Kaiser Permanente (KP) Medical Necessity Criteria policy stated that KP "utilizes established medical evidence such as published articles, medical research studies and published medical guidelines/criteria as the basis for authorization… to assess whether the medical services requested are appropriate for the condition and provided in the most appropriate setting." The Authorization of Services policy states that "benefits are no more restrictive in amount, duration, and scope than that used in the … State Medicaid program as indicated in state statutes and regulations and the State Plan." However, policies and procedures do not specify the medical necessity criteria outlined in the State Medicaid Plan; nor do they refer staff members to another source to obtain these criteria. Therefore, it is not apparent that UM reviewers ensure that the State-defined medical necessity criteria are applied in making all final UM determinations for Access KP members.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
HSAG also informed staff members on-site that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, HSAG recommended that KP update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.		
Required Actions: Colorado Access must ensure that KP updates its UM policies and procedures applicable to Access KP authorization decisions to clearly define the medical necessity criteria outlined in the State Medicaid Plan.		
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; – Service has the ability to achieve age-appropriate growth and development; – Service has the ability to attain, maintain, or regain functional capacity; – There is no other equally effective or substantially less costly course of treatment suitable for the client's needs. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments.	• **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf**). See Policy Statement, paragraph 2 (highlighted); and • Last paragraph on pg 1: Benefits are no more restrictive in amount, duration and scope than that used in the Medicare and State Medicaid program as indicated in state statutes and regulations and the State Plan for Senior Advantage, CHP+ and Access KP covered persons. • **Medical Necessity Criteria, Policy ID #: 6891-14 (MedicalNecessityCriteria16.pdf).** See Policy Statement, paragraph 1 – Demonstrates criteria applied to requested services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—1.1.1.50		
7. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Exhibit A—3.9.1.2.1	• **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Procedure to Implement Policy, pgs 4-6 – demonstrate process for requesting authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit A—3.9.1.2	• **Monitoring of Reviewer Reliability, Policy ID #: 6891-15. (See MonitoringOfReviewerReliability16.pdf).** Policy Statement. Demonstrates how Kaiser Permanente Colorado monitors staff for consistency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit A—3.9.1.2	• **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Policy Statement, pg 2, paragraph 1. Demonstrates process for physician consultation. • **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(TimlinessofUMDecisionMaking16.pdf). See Procedure to Implement Policy – 1. Pre-service, a. Urgent Care, 2 – demonstrates process for consulting with provider when necessary.	
10. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.9.1.5	• **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Policy Statement, pg 2, paragraph 1. Demonstrates process for seeking clinical expertise during decision making. • **Denial of Coverage, Policy ID #: 6891-12 (DenialofCoverage16.pdf)** See Policy Statement, paragraph 3. Demonstrates process for seeking clinical expertise during decision making. • **Affirmation Statement for Board Certification, Policy ID #: 6891-02 (AffirmationStatementofBoardCertification16.pdf).** See Policy Statement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* Contract: Exhibit A—3.9.1.2	• **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Procedure to Implement Policy, highlighted sections on pgs 5 and 6. Demonstrates authorization notification regarding amount, duration and scope. • **Denial of Coverage, Policy ID #: 6891-12 (DenialofCoverage16.pdf).** See Policy Statement, pg 2, paragraph 2 (highlighted).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10 CCR 2505-10 8.209.4.A.3(c) Contract: Exhibit A—4.1.1.4.6	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06 (TimlinessofUMDecisionMaking16.pdf).** See highlighted section on pg 3.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Timeliness of UM Decision-Making and Notification policy specified that the timeline for standard authorization decisions was 10 calendar days for Access KP members. However, HSAG identified in denial record reviews that three of 10 records included notices of action noncompliant with this time frame.		
Required Actions: Colorado Access must ensure that KP provides notices of action for standard authorization decisions within 10 calendar days from receipt of the request for service.		
13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505-10 8.209.4.A.3(c) Contract: Exhibit A—4.1.1.4.6.2	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06 (TimlinessofUMDecisionMaking16.pdf).** See highlighted section on pg 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505-10 8.209.4.A.1 Contract: Exhibit A—4.1.1.4.5.1	• **Notice of Action – Denial, Medical Necessity (NOA_AKP Med Necessity Denial.pdf)** • **Notice of Action – Benefit Denial with Appeal Rights (NOA_AKP Benefit Denial.pdf)** • **CATLAR Notice of language assistance (CATLARTaglines_CM_CO_2016_Ltr.pdf).** Demonstrates state specific non-English language assistance letter added to all essential member communications.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During on-site denial record reviews, HSAG noted that some template language included in the NOA used wording—e.g., *relevant* information, *adverse benefit determination*—that did not ensure ease of understanding or approach sixth grade reading level. HSAG found one of 10 records included information in the free-form text explanation of the *reason for denial* to be a highly technical explanation of the criteria applied, and further noted that information included the free-form text explanation of *alternatives available* may be irrelevant to Medicaid members (e.g., members may choose to pay for services or bill another insurance they may have). HSAG also observed that the *Appeal Rights* section included information that could be confusing for the member and was written in language difficult for a member to understand.		
Required Actions: Colorado Access must ensure that KP's NOAs to Access KP members ensure ease of understanding (sixth-grade reading level where possible).		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505-10 8.209.4.A.2 Contract: Exhibit A—4.1.1.4.2.2.	• **Denial of Coverage, Policy ID #: 6891-12 (DenialofCoverage16.pdf).** See Policy Statement, pg 3, #1 (highlighted). • **Notice of Action – Denial, Medical Necessity (NOA_AKP Med Necessity Denial.pdf)** • **Notice of Action – Benefit Denial with Appeal Rights (NOA_AKP Benefit Denial.pdf).**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the Member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address.	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06 (TimlinessofUMDecisionMaking16.pdf).** See highlighted section on pgs 5, 6 and 7. • **Access KP Guide (FINAL-Access KP Guide.7.16.pdf).** See highlighted section on pg 14. • **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Policy Statement, pg 2, paragraph 4.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
○ The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. ○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)*		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 431.211, *431.213*, and *431.214* 10 CCR 2505-10 8.209.4.A.3 Contract: Exhibit A—4.1.1.4.3, 4.1.1.4.4, and 4.1.1.4.6		
Findings: KP's Timeliness of UM Decision-Making and Notification policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. Staff members stated that KP does not terminate or reduce previously approved authorizations for members. However, the policy omitted reference to other notification timeframe requirements applicable to Medicaid members, specifically: • For service authorization decisions not reached within the required time frames on the date that time frames expire. • If the Contractor extends the time frame, no later than the date the extension expires. • For denial of payment, at the time of any action affecting the claim. In addition, staff members were unable to confirm whether or not claims payment procedures were aligned with the requirement to provide an NOA to the member at the time of any action affecting the claim (i.e., denial of payment decisions).		
Required Actions: Colorado Access must ensure that KP updates its policies and procedures to address all notification time frames applicable to Access KP members as outlined in the requirement. Colorado Access must also confirm that KP's claims payment procedures are aligned with the requirement to provide an NOA to the member at the time of denial of claim payment (excludes administrative denials).		
17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Exhibit A—4.1.1.4.6.1	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06 (TimlinessofUMDecisionMaking16.pdf).** See #2 c on pg 3 and highlighted section on pg 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10 CCR 2505-10 8.209.4.A.3(c)(i) Contract: Exhibit A—4.1.1.4.6.1	• **Timeliness of UM Decision-Making and Notification Policy ID #: 6891-06 (TimlinessofUMDecisionMaking16.pdf).** See #2 c on pg 3 (highlighted).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor provides that compensation to individuals or entities that conduct UM 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 E—1.1	• **Denial of Coverage, Policy ID #: 6891-12 (DenialofCoverage16.pdf).** See Policy Statement, pg 1, paragraph 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. 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:	• **Coverage of Emergency Services Policy ID #: 6891-03. See CoverageofEmergencyServices16.pdf.** Policy Statement, paragraph 4, pgs 1-2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—1.1.1.18		
21. The Contractor defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—1.1.1.19	• **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, highlighted section.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. 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)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—None	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, paragraphs 2 and 3, pg 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Exhibit A—4.1.1.4.1.4.2 and Exhibit I—1.1.2.8.2	• **Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See Emergency Care, pg 9. • **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, paragraph 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #20 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but 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. – Serious dysfunction of any bodily organ or part. • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.1	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, paragraph 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—1.1.1.18 and 3.5.4.2.2	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. 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)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.3	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. 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.	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(d)(3) *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.4		
28. The Contractor defines "poststabilization care" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown* Contract: Exhibit A—1.1.1.61	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.5	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Per contract with the Department, Access KP covered services are limited to a defined set of ambulatory primary care and specialty services. All other Medicaid covered services for members are provided within the Medicaid fee-for-service (FFS) program. Post-stabilization services—determined to be primarily inpatient services—are the responsibility of the FFS program. As such, Access KP does not apply authorization processes and is not financially responsible for post-stabilization services. Therefore, HSAG scored all post-stabilization coverage and authorization requirements as *Not Applicable.*		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor'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 Contractor must give the treating physician the opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—1.1.1.61	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Per contract with the Department, Access KP covered services are limited to a defined set of ambulatory primary care and specialty services. All other Medicaid covered services for members are provided within the Medicaid FFS program. Post-stabilization services—determined to be primarily inpatient services—are the responsibility of the FFS program. As such, Access KP does not apply authorization processes and is not financially responsible for post-stabilization services. Therefore, HSAG scored all post-stabilization coverage and authorization requirements as *Not Applicable.*		
31. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.8	• **Coverage of Emergency Services Policy ID #: 6891-03.** See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Per contract with the Department, Access KP covered services are limited to a defined set of ambulatory primary care and specialty services. All other Medicaid covered services for members are provided within the Medicaid FFS program. Post-stabilization services—determined to be primarily inpatient services—are the responsibility of the FFS program. As such, Access KP does not apply authorization processes and is not financially responsible for post-stabilization services. Therefore, HSAG scored all post-stabilization coverage and authorization requirements as *Not Applicable.*		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Exhibit A—3.5.4.2.7	• **Coverage of Emergency Services Policy ID #: 6891-03**. See Policy Statement, pg 2, paragraph 2. KPCO emergency services are paid without retrospective review.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Per contract with the Department, Access KP covered services are limited to a defined set of ambulatory primary care and specialty services. All other Medicaid covered services for members are provided within the Medicaid FFS program. Post-stabilization services—determined to be primarily inpatient services—are the responsibility of the FFS program. As such, Access KP does not apply authorization processes and is not financially responsible for post-stabilization services. Therefore, HSAG scored all post-stabilization coverage and authorization requirements as *Not Applicable.*		
33. The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic, and treatment components according to State and federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards and periodicity schedule. • The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under, including lead testing and immunizations. • The Contractor must implement the American Academy of Pediatrics' Bright Futures periodicity schedule. 10 CCR 2505-10 8.280.2, 8.280.8A, and 8.280.4.A (1) and (2) Contract: Exhibit A—3.7.5.2.2.		☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Colorado Access and KP provided no documentation of policies, procedures, or processes related to provision of EPSDT services for members ages 20 and under. Staff members stated that while EPSDT-related processes were in place within various operational components of the KP delivery system, KP had no written policies and procedures to address the provision of all required screening, diagnostic, and treatment components of the EPSDT program. Staff members also stated that KP has implemented the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, but provided no evidence to confirm that it had done so. Staff members acknowledged that it was KP's intent to develop comprehensive EPSDT policies and procedures once staff fully understood all EPSDT requirements to be addressed in the policy.		
Required Actions: Colorado Access must ensure that KP develops and implements written policies and procedures related to comprehensive EPSDT services and requirements. Procedures should address mechanisms used by KP to implement the AAP Bright Futures periodicity schedule.		

34. The Contractor must ensure the provision of all required components of periodic health screens to EPSDT beneficiaries who request it. Screening includes:
• Comprehensive health and developmental history.
• Comprehensive unclothed physical examination.
• Appropriate vision testing.
• Appropriate hearing testing.
• Appropriate laboratory tests.
  – As defined in the periodicity schedule.
  – Lead toxicity blood screening between 36 and 72 months of age if not previously tested.
• Dental screening services, including an assessment of mouth, oral cavity, and teeth; and referral to a dentist for children by 1 year of age or at the eruption of the first tooth.
• Developmental screening to determine whether a child's emotional and developmental processes fall
		☐ Met
		☒ Partially Met
		☐ Not Met
		☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
within a benchmarked range according to the child's age group and cultural background. Screening includes self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills, and appropriate mental/behavioral health screening. *42 CFR 441.56 (b) (i)–(vi) and 441.59 (b)* 10 CCR 2505-10 8.280.8.C and 8.280.4.A (3)(a–d) Contract: Exhibit A—3.7.5.2.2		
Findings: Staff members stated that KP has defined protocols within the Kaiser electronic health record that address the components of periodic health screens outlined in the requirement. However, KP provided no documentation or evidence to confirm that it had done so.		
Required Actions: Colorado Access must ensure that KP provides all required components of periodic health screens to EPSDT beneficiaries.		
35. The Contractor must provide diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any EPSDT screening and diagnostic procedure—even if the services are not included in the plan—including: • Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids. • Dental care at as early an age as necessary for relief of pain and infections, restoration of teeth, and maintenance of dental health. • Appropriate immunizations. (If determined at the time of screening that immunization is needed and		☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e–g) and 8.280.4.C (3) Contract: Exhibit A—3.7.5.2.2		
Findings: KP's network or primary care and specialist providers and ancillary services appeared to provide many of the diagnostic and treatment services required as a result of EPSDT screenings, even if the services are not covered under the Access KP Plan. Staff members stated that primary care practitioners make referrals as needed within the KP network and then determine whether the services are billed to the Access KP Plan or Medicaid FFS. However, KP provided no documentation of procedures or other processes which address provision of diagnostic and treatment services identified through EPSDT screenings—even if not covered in the plan.		
Required Actions: Colorado Access must ensure that KP has policies or procedures to address provision of diagnostic and treatment services needed as a result of EPSDT screening, including vision services, dental services, and immunizations. Colorado Access must also ensure that members receive or are referred to EPSDT-related diagnosis and treatment services not covered under the Access KP contract.		
36. A referral from the member's primary care physician may be required for EPSDT-related care provided by anyone other than the primary care physician. • Members may self-refer for routine vision, dental, hearing, or mental health services; or family planning services. • Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing, and pharmaceuticals. 10 CCR 2505-10 8.280.6 and 8.280.7 Contract: Exhibit A—3.7.5.2.2		☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Health First Colorado member handbook states that members do not need approval for routine hearing, vision, dental, mental health, or family planning services. The Access KP member guide lists many EPSDT-related services—including dental services, home health services, hearing services, home health services, private duty nursing, prescription drugs and mental health services—as wraparound benefits excluded from the Access KP plan but which may be provided through Health First Colorado (Medicaid FFS). The guide stated that no referral is needed for wraparound services; however, the Health First Colorado member handbook listed some of these benefits as requiring prior authorization. Staff members stated that some services not covered by Access KP may be authorized and provided within the KP delivery system and would be billed to Medicaid FFS. Staff also stated that providers obtained authorization through the Medicaid FFS system for services outside the scope of the Access KP contract (i.e., Medicaid FFS) or referrals out of network. In the absence of a policy focused on provision of EPSDT services, it was unclear whether KP providers were responsible for obtaining authorization for EPSDT-related services not covered under the Access KP plan yet provided within the KP network; seeking authorization from Medicaid FFS for wraparound benefits (defined as services not covered under the Access KP plan), some of which included EPSDT-related services; and procedures for seeking authorization through either KP or Medicaid FFS, as appropriate.		
Required Actions: Colorado Access should ensure that KP develops EPSDT policies and procedures that clearly outline the requirements and provider expectations related to referrals and authorizations for EPSDT-related care in or out of network.		
37. The Contractor defines "medical necessity for EPSDT services" as: • A service that is found to be an equally effective treatment among other less conservative or more costly treatment options, and • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.		☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: • The service is medically necessary. • The service is in accordance with generally accepted standards of medical practice. • The service is clinically appropriate in terms of type, frequency, extent, and duration. • The service provides a safe environment or situation for the child. • The service is not for the convenience of the caregiver. • The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1 and 8.280.4.E Contract: Exhibit A—1.1.1.24		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: KP provided no documentation that addressed the medical necessity criteria for EPSDT services and no evidence that UM authorization processes incorporate the "medical necessity" definition specific to EPSDT. HSAG noted that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 and 8.076.1.8.1 (effective August 30, 2016)—clarifies EPSDT-specific medical necessity criteria. Therefore, HSAG recommends that KP refer to the CCR and update the definition of "medical necessity" for EPSDT services accordingly.		
Required Actions: Colorado Access must ensure that KP policies and procedures incorporate the definition of "medical necessity" for EPSDT services as outlined in the State Medicaid Plan.		
38. The Contractor ensures provision of all required components of periodic health screens through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) Contract: Exhibit A—3.7.5.2.2		☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: While staff members stated that KP had various operational processes in place to ensure provision of periodic health screens by providers, neither Colorado Access nor KP provided evidence of systematic communications with network providers regarding the Department's EPSDT requirements, including provider-specific responsibilities related to EPSDT requirements.		
Required Actions: Colorado Access must ensure that Access KP providers receive systematic—i.e., regular and periodic—communications regarding the Department's EPSDT requirements.		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	8	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	24

Total Score ÷ Total Applicable	=	71%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care physician (PCP) provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either a PCP or physician specialist, but not both. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Exhibit A—3.6.1.1.2 and 3.6.1.1.8	• **Practitioner Availability and Sufficiency of Services Policy Number: 7204-09 (Practitioner Availability and Sufficiency of Services_121316_Draft.pdf).** See 5.0 Provision on pg 3. 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. Note: Currently in draft form due to updates. This is a current policy in use. • **Kaiser Permanente Colorado Denver Boulder Medicaid (CHP+ and Access KP Membership) Network Adequacy Report (Medicaid_CHP+ Network Adequacy Analysis.pdf).** See Access KP results on pgs 4-8.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers and Medicaid members, considering distance, travel time, and means of transportation used by members. – Members have their choice of at least two participating providers within their zip code or within thirty minutes' driving time from their location, whichever area is larger. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Exhibit A—3.6.1.1.2, 3.6.1.3.2, and 3.6.1.1.11	• **Kaiser Permanente Colorado Denver Boulder Medicaid (CHP+ and Access KP Membership) Network Adequacy Report (Medicaid_CHP+ Network Adequacy Analysis.pdf).** See Access KP results on pgs 4-8. • **Access KP Membership and Provider Map.pdf** This document graphically displays member locations vs. practitioner and facility locations. • **Denver Boulder Locations.pdf** This document provides a map and the addresses of the Denver / Boulder Medical Office Buildings.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor provides female members with direct access to a women's health 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 A—3.6.1.1.5	• **Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See Note under Find the Right Doctor for You. Female members may elect an OB / GYN as their PCP. • Also see Specialty Care, pg 7. All members have access to specialty care, including obstetrics / gynecology.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Contract: Exhibit A—3.7.3.5	• **Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See Find the Right Doctor for You on pg 6 and Specialty Care, pg 7. This provides information for selecting a PCP of the member's choosing.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The KP provider network offers Access KP members both the primary care and specialist physicians employed by Colorado Permanente Medical Group and approximately 2,000 additional contracted specialist providers. Staff members stated that practitioners make referrals to specialists within the KP provider network as needed to meet the needs of the member. The KP integrated provider system and additional availability of numerous types of specialists within the external contracted network appear to provide sufficient ongoing access to specialists for members with special healthcare needs. Staff members stated that Access KP UM staff approve all referrals within the KP network, whether billed under the capitated Access KP contract or to Medicaid FFS. However, because Access KP members are required to have a referral to see a specialist, Colorado Access should ensure that KP referral or UM policies and procedures clearly specify that members with special healthcare needs (who use specialists frequently) are allowed to maintain these types of specialists as PCPs or are allowed direct access or standing referrals to specialists.

Required Actions:
Colorado Access must ensure that Access KP policies and procedures specify that persons with special healthcare needs who use specialists frequently are allowed to maintain these types of specialists as PCPs or be allowed direct access or standing referrals to specialists.

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides for a second opinion from a qualified health care professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit A—3.6.1.1.7	• **Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See pg 31, right column, last bullet – You have the right to a second opinion by a Kaiser Permanente physician. • **Access KP Guide (FINAL-Access KP Guide.7.16.pdf).** See highlighted section on pg 5.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit A—3.6.1.2.1	• **Access KP Guide (FINAL-Access KP Guide.7.16.pdf).** See the Referrals for Covered Services section on pg 5. • **Authorization of Services, Policy ID #: 6891-13 (Authorization ofServices16.pdf).** See Policy Statement, pg 3, paragraph 1 for description of authorization process for contracted and non-contracted providers.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Access KP covered services include a defined set of approximately 2,100 ambulatory service Current Procedural Terminology (CPT) codes that have been historically provided within the KP provider system. By definition, KP is able to provide all covered services of the contract within its network. Therefore, HSAG scored this requirement as *Not Applicable.*		
7. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit A—3.6.1.2.2	• **KFHP External Provider Contract Template (KFHP Template_CO_Standard.pdf).** See highlighted section 3.3 Member Hold Harmless on pg 9 and # 3 in Exhibit 3, pg 34. Providers may not charge the member more than their cost share amount for plan covered services.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: As this requirement is directly related to requirement number 6, HSAG has determined this requirement to be *Not Applicable.* Payment and costs for all out-of-network services for Access KP members are the responsibility of the Medicaid FFS system.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary (e.g., emergency services). • Requires a policy and procedures *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit A—3.6.1.4.3	• **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07 (Access to Care Policy.2017.pdf).** See Attachment A, Access Requirement, After Hours Care and Emergency Care – Medical, Behavioral, substance abuse. This policy describes the standards for 24 hours a day, 7 days a week member access to advice, appointments and services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. • The Contractor's provider network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit A—3.6.1.4.1, 3.6.1.4.2	• **Denver/Boulder Member Resource Guide 2017 (cco_member_resource_guide.pdf).** See pg 7, Care Available to You. All services are available to all members. Hours of operations per facility are available at kp.org. • **Denver Boulder Locations.pdf**. This document provides a map and the addresses of the Denver / Boulder Medical Office Buildings. Pg 2 provides After-hours and Emergency Care options.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: • Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor.	• **KFHP External Provider Contract Template (KFHP Template_CO_Standard.pdf).** See highlighted text on page 5. • **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07 (Access to Care Policy.2017.pdf).** See Attachment A for all Accessibility of Services time standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Non-urgent, symptomatic care is scheduled within 10 days of the member's request for services. • Adult, non-symptomatic well care physical examinations are scheduled within 45 days. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit A—3.6.1.5.2		
11. The Contractor communicates all scheduling guidelines in writing to participating providers. Contract: Exhibit A—3.6.1.5.4	• **Provider Manual – Quality Assurance and Improvement (2016_Provider_Manual_Sec8_Quality.pdf).** See pg 22, Accessibility Standards. Describes the standards, goals and methods of measurement for appointment scheduling guidelines. • **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07 (Access to Care Policy.2017.pdf).** See Attachment A for all Accessibility of Services time standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Exhibit A—3.6.1.5.4	• **Member Access to Care Policy and Procedure (Accessibility of Services) Policy ID #: 7204-07 (Access to Care Policy.2017.pdf).** See Procedure to Implement Policy, paragraph 1, pg 2. This policy discusses timely access requirements, monitoring processes and results that may lead to a corrective action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that members have access to EPSDT Contractor-covered services in compliance with 42 CFR, Sections 441.50 through 441.61. • The Contractor must make available a variety of individual and group providers qualified and willing to provide EPSDT services. • The Contractor shall inform all Medicaid-eligible persons through age 20 that EPSDT services are available. *42 CFR 441.61(b)* Contract: Exhibit A—3.7.5.2 and 3.7.5.2.1		☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. If the screening provider is not licensed or equipped to render necessary EPSDT-related treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. • The Contractor advises participating providers of EPSDT services available through other entities. 10 CCR 2505-10 8.280.4.C.2 Contract: Exhibit A—3.5.4.1.2		☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Staff members described referral processes commonly applied to all members within the KP provider network, and the KP Medical Director communicated a general overview of the KP pediatric quality assurance program; however, KP did not have EPSDT-specific policies and procedures to address the requirement that providers refer members for further EPSDT-related diagnosis and treatment either to an appropriate practitioner or to Healthy Communities. KP also did not provide evidence of informing providers of EPSDT-related services available through other entities or of information pertaining to Healthy Communities.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: Colorado Access must ensure that KP addresses EPSDT diagnosis and treatment referral requirements, educates providers about Healthy Communities, and advises providers of EPSDT services available through other entities.		
15. 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. (Includes policies and procedures, cultural competency training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Exhibit A—3.7.4.3	• **CATLAR Notice of language assistance (CATLARTaglines_CM_CO_2016_Ltr.pdf).** Demonstrates state specific non-English language assistance letter added to all essential member communications (e.g. Evidence of Coverage, Explanation of Benefits). • **Kp.org, Other Languages:** http://info.kaiserpermanente.org/html/gethelp/colorado.html • **Diversity Training Overview (diversity_l_and_d_program_overview_2016.pdf).** This document illustrates the diversity training requirements for Kaiser Permanente CO employees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	1	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	11

Total Score ÷ Total Applicable	=	85%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor including: • The requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract. *42 CFR 438.230(a)(1)* *Requirement to be updated 7/2017—see appendix)* Contract: 19.A; Exhibit A—3.1.3.5 and 3.1.3.5.1	Documentation: • **Access-KP Delegation Agreement Final** o Page 16: Article III.A. Colorado Access Accountability o Page 1 o Page 4: Article II, Delegate Responsibilities, Duties and Obligations o Page 13: II.K.C: Deliverables o Page 18: III.J: Delegation Audits o Page 18: III.K: Other Monitoring Activities o Page 19: III.L: Monitoring of Delegate's Performance Improvement Projects • **Access-KP CMP – Final (also Page 59: Exhibit D: Contract Monitoring in the Access-KP Delegation Agreement Final) –** Outlines the entire oversight process of the contract.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Findings:

The KP delegation agreement specified that the following functions were delegated to KP: care management, communications, finance, claims payment, data management/information technology, member enrollment, utilization management, appeals and grievances, network management, and provision of primary and specialty services. The Department's contract with Colorado Access specifies that Colorado Access is accountable for all 42 CFR Part 438 requirements related to these delegated activities. The Access KP CMP outlined the components of Colorado Access oversight and audit of contract deliverables, which primarily included review of defined deliverable reports from KP to Colorado Access, an annual on-site review for claims verification and review of a sample of care coordination files, and a delegation audit—not yet designed or implemented at the time of HSAG review—consisting of a detailed review of "deliverables." Colorado Access submitted no documents which provided evidence that it had implemented or intended to implement oversight or audit of KP's operational processes related to 42 CFR Part 438. The federal managed care requirements specified in 42 CFR Part 438 include extensive policy, procedure, and operational process requirements; therefore, Colorado Access must include in its CMP a mechanism to

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
ensure compliance with the requirements of 42 CFR Part 438 appropriate to the service or activity delegated to the subcontractor and/or must demonstrate accountability for those processes within Colorado Access operations. HSAG recommends that Colorado Access consider designing the proposed delegation audit to comprehensively address all applicable federal requirements related to the subcontractor's delegated activities.		
Required Actions: Colorado Access must define and implement mechanisms to maintain oversight and accountability for requirements of CFR 42 Part 438 applicable to the services and activities delegated to the subcontractor.		
2. Before any delegation, the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated. *42 CFR 438.230(b)(1)* *Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.1.3.5.2	Documentation: • **Readiness Review Access-KP FINAL –** Details pre-program evaluation of KP's abilities to service the contract	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. There is a written agreement with each delegate. The written delegation agreement: • Specifies the activities and reporting responsibilities delegated to the subcontractor. • Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. • Requires the subcontractor to perform in accordance with the terms and conditions of the Contractor's contract with the State and to comply with all applicable federal and State laws including: – Age Discrimination Act of 1975 – Age Discrimination in Employment Act	Documentation: • **Access-KP Delegation Agreement Final** o ("Specifies the activities and reporting responsibilities delegated to the subcontractor…") : 1. Page 4: Article II Delegate Responsibilities, Duties and Obligations 2. Page 19: Article IV.A: Breach by Delegate and Associated Remedies	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
– Americans with Disabilities Act of 1990 (ADA) – Clean Air Act – Equal Employment Opportunity – Equal Pay Act of 1963 – Federal Water Pollution Control Act – Immigration Reform and Control Act of 1986 – Section 504 of the Rehabilitation Act of 1973 – Title VI of the Civil Rights Act of 1964 – Title VII of the Civil Rights Act of 1964 – Title IX of the Education Amendments of 1972 – All laws and regulations prohibiting discrimination in program participation or benefits (persons with disabilities) OR on the basis of race, color, national origin, age, sex, religion, or handicap (including Acquired Immune Deficiency Syndrome [AIDS] or AIDS-related conditions) • Requires the subcontractor to provide certificates of insurance that verify insurance requirements (with minimum limits) as defined in the contract with the State, including: – Workers compensation. – General liability. – Protected health information liability. – Automobile liability.	o ("Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate…") : 1. Page 19: Article IV: Breach, Remedies, and Termination With Cause; 2. **Access-KP CMP Final.** Pages 5-6, Sec 5.2, 5.3, 5.4, 5.9 (also in **Access-KP Delegation Agreement Final:** Page 59: Exhibit D: Contract Monitoring Plan) o ("Requires the subcontractor to perform in accordance with the terms and conditions of the Contractor's contract with the State and to comply with all applicable federal and State laws including…") : Page 30: Article VII.S: Applicable Law, Jurisdiction, and Venue o ("Requires the subcontractor to provide certificates of insurance that verify insurance requirements (with minimum limits) as defined in the contract with the State, including…") : Page 25: Article VII.A: Insurance Requirements.	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
42 CFR 438.230(b)(2) *Requirement to be updated 7/2017—see appendix)* Contract: 19.A, 20.A, 13.B, and 13.C; Exhibit A—3.1.3.5.3 and 3.1.3.3		
4. The Contractor monitors the subcontractor's performance on an ongoing basis and subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. Per the Kaiser Delegation Agreement, the delegate is responsible for all of the following: • Care management • Communications • Finance • Claims payment • Data management/information technology • Member enrollment • Utilization management • Appeals and grievances • Network management • Provision of primary and specialty services *42 CFR 438.230(b)(3)* *Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.1.3.5.4 Kaiser Delegation Agreement—II.A	Documentation: ("The Contractor monitors the subcontractor's performance on an ongoing basis and subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations….."): • **Access-KP Delegation Agreement Final** o Page 13: II.K.C: Deliverables o Page 18: III.J: Delegation Audits o Page 18: III.K: Other Monitoring Activities o Page 19: III.L: Monitoring of Delegate's Performance Improvement Projects o Page 34-50: Exhibit A: Delegated Services Deliverables • **Access-KP CMP – Final (also Page 59: Exhibit D: Contract Monitoring in the Access-KP Delegation Agreement Final)** o Pages 4-6: Sec 5.1 – 5.9 ("Per the Kaiser Delegation Agreement, the delegate is responsible for all of the following:…")	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	• **Access-KP Delegation Agreement Final** o Page 4: Article II.A: Delegated Services	

Findings:

Colorado Access had defined an Access KP CMP which stated that Colorado Access would perform oversight of the Access KP contract requirements, including monitoring of the subcontractor's delegated responsibilities, through annual on-site visits; regular monitoring of deliverables (reports specified); communications with members; medical records; claims, grievances and appeals; secret shopper calls; other reports; and a delegation audit every six months, consisting of a detailed review of KP's delivery of each "deliverable" (not defined). Colorado Access and KP had a joint operating group that met weekly to discuss the implementation of the structural components of the contract. Colorado Access and KP also jointly participated in the Performance Improvement Advisory Committee (PIAC), designated as the oversight mechanism for outcome measurement goals of the Access KP pilot program. HSAG's findings related to implementation of ongoing and formal review of the subcontractor's performance to date were as follows:

- Colorado Access had developed a deliverable tracking schedule to monitor receipt of deliverables from KP and reporting of deliverable reports to the Department. At the time of review, Colorado Access had documented receipt of numerous deliverable reports. Although staff members stated that Colorado Access reviewed each deliverable report to compare to contract requirements, Colorado Access did not document a qualitative assessment of the reports or any conclusions that may have resulted from such. Therefore, documentation of using the reports for oversight of the subcontractor's performance was not evident.
- Colorado Access conducted one on-site review in September 2016, which consisted of an encounters/claims validation (30 records) and a medical record review (seven records) of advance directives, many elements of care coordination, and interpreter services. Colorado Access submitted a corrective action plan to KP. However, Colorado Access provided no evidence of qualitative analysis of findings of the audit nor evidence that KP's operational processes (e.g., policies and procedures, staff interviews) were evaluated, as stated in the CMP.
- At the time of on-site review, the delegation audit outlined in the CMP (due January 2017) had not been designed, conducted, or scheduled. Therefore, Colorado Access could provide no evidence of the components of the delegation audit intended to perform a detailed formal review of the subcontractor's "deliverables."
- The CMP failed to address oversight processes related to every area of responsibility (such as utilization management) delegated to the subcontractor in the KP delegation agreement. In addition, the CMP did not clearly define processes for evaluation of KP's operational processes related to each category of delegated activity to ensure that the contact requirements outlined in Appendix B of the CMP were met.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
• Due to the fact that most functions and requirements of the Access KP contract were delegated, it would appear that adequate oversight and monitoring by Colorado Access would require extensive resources. It was not apparent to HSAG which Colorado Access organizational resources were engaged in the oversight and monitoring processes. Colorado Access should reassess its subcontractor monitoring processes to ensure that processes comprehensively address all subcontracted activities, mechanisms defined are implemented, and results of all monitoring activities are analyzed and documented.		
Required Actions: Colorado Access must: • Ensure that its oversight and monitoring of the subcontractor include assessment of all areas of responsibility delegated to KP as well as thorough assessment of the detailed contract requirements. • Document results of all oversight activities and KP deliverables in a manner that reflects analysis of findings and related qualitative conclusions. • Design and implement the delegation audit (due January 2017) timely, as defined in the CMP.		
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action. *42 CFR 438.230(b)(4)* *Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.1.3.5.5	Documentation: • **KP Quality Monitoring Audit Results Letter –** Provided to KP with results of the onsite audit by COA Fall, 2016 • **2016.11.29-KP Corrective Action Plan.9.26.16 audit.KP response** - Corrective Action Plan provided to KP as a result of the audit, with their response • **2016.11.29-KP Corrective Action Plan Item 1-Longitudinal Plan of Care with Patient Goals display –** Additional KP response to audit results and subsequent Corrective Action Plan	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The KP delegation agreement specified that the failure of the delegate to perform any of its material obligations, in whole or in part or in a timely manner, constitutes a breach, and that KP has 30 days to cure such breach. The Access KP CMP addressed corrective actions in isolated areas of the document, but was unclear regarding expectations for corrective action and related time frames overall. Staff members stated that, with the exception of		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
identified individual member issues, time frames and expectations for corrective actions were negotiable based on other operational priorities of the subcontractor. Agendas of the joint operating group weekly meetings indicated that various issues of contract implementation were being addressed ongoing. The minutes of the PIAC reflected no review or oversight of KP deliverables, no audit activities, and no corrective actions implemented to date. Colorado Access provided documentation of an example of one formal KP corrective action resulting from on-site audit of KPs care coordination files. KPs corrective action plan indicated that KP's corrective actions would be implemented nine to 11 months from the date of Colorado Access' required actions.		
Required Actions: Colorado Access must review its CMP and processes to ensure that the subcontractor's performance is adequately analyzed and that all areas of potential deficiency are assessed and corrective actions implemented in a timely manner. Colorado Access should consider more clearly addressing in its CMP expectations for corrective actions.		
6. In the event that the Contractor allows a subcontractor to perform any care coordination activities, the agreement with that subcontractor shall comply with all applicable requirements of the contract (with the Department). Applicable care coordination requirements include: • Providing staff necessary to ensure that care coordination functions are performed. • Maintaining a toll-free telephone line that members may call regarding care coordination issues. • Ensuring that care coordination is provided for members around all covered services and Medicaid FFS services. • Defining care coordination as the process of identifying, screening, and assessing members' needs (medical and nonmedical); identifying of and	Documentation: • **Access-KP Delegation Agreement Final** o Page 1 o Page 2: Article I: Definitions: "Care Coordination," "Care Management" o Page 5: Article II.C: Delegate's Formal System of Care Coordination: Sections A-D o Page 7: Article II.D: Medical Management Practices	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
referring to appropriate services; and coordinating and monitoring of individualized care plans. • Ensuring care coordination that reflects the needs of members to achieve their desired health outcomes in an efficient and responsible manner, including documentation of the member's desired health outcomes and identification of other members of that member's care coordination team in the care coordination care plan. • Assessing current care coordination services provided to members to determine if the providers involved in a member's care are providing necessary care coordination services and which care coordination services are insufficient or not provided. • Providing all care coordination services not provided by another source. • Working with providers responsible for the member's care to develop a plan for regular communication with the person(s) responsible for the member's care coordination. • Reasonably ensuring that all care coordination services, including those provided by other individuals or entities, meet the needs of the member. • Ensuring that the care coordination team has access to an integrated care plan across provider and community organizations, including a		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
comprehensive psychosocial assessment and a multidimensional plan addressing social, physical, and behavioral health needs. • Developing a formal system of care coordination for its members. All elements of the formal system of care coordination shall be documented in the care plan, including: – Assessing the member's health and health behavior risks and medical and non-medical needs, determining if a care plan exists, and creating a care plan if needed. – Linking members both to medical services and to non-medical, community-based services such as child care, food assistance, services supporting elders, housing, utilities assistance, and other non-medical supports as necessary. – Providing assistance during care transitions from hospitals or other care institutions to home or community-based settings or during other transitions such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. – Providing or working with community-based organizations to arrange for an individual to act as a care coordinator for each member during any transitions and communicating with every member to which they are assigned, once while the member is in the		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
hospital and again within 48 hours of that member's discharge. – Providing solutions to problems encountered by providers or members in the provision or receipt of care. – Following up with members to assess whether the member has received needed services and is on track to reach their desired health outcomes. – Providing care coordination activities linguistically appropriate to the member and consistent with the member's cultural beliefs and values. – Providing care coordination responsive to the needs of special populations (e.g., physically or developmentally disabled, members with HIV, the aged). – Providing care coordination that aims to keep members out of a medical facility or institutional setting and to provide care in the member's community or home to the greatest extent possible. Contract: Exhibit A—1.1.1.5, 3.3.5.1.2, and 3.7.2.1 through 3.7.2.4.1		
Findings: The Access KP delegation agreement assigned responsibility for all care management activities to KP. Although the agreement outlined many care coordination requirements reflected in the Access KP contract, it did not specifically align with the language of the requirements in the contract (i.e., the		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
agreement outlined the components of the formal system of care defined in the Colorado Access RCCO contract rather than the requirements specified in the Access KP contract). The agreement also failed to include several requirements of the Access KP contract, such as requirements for maintaining sufficient staffing to ensure that care coordination requirements are performed, maintaining a toll-free number for members to call related to care coordination issues, and documenting all elements of the formal system of care coordination in the care plan. Colorado Access had obtained and reviewed KP's *Formal System of Care Coordination*, but provided no documentation of Colorado Access' review and assessment of the sufficiency of the *Formal System of Care Coordination* in relation to Access KP contract requirements. Discussions during the on-site interview indicated that KP was experiencing difficulty performing responsibilities for care coordination of the full continuum of services for members because the Access KP contract is limited to a defined set of ambulatory services delivered only within the KP network. In addition, staff members stated that KP does not have access to data related to the FFS elements of the continuum of care (e.g., SDAC data). Nevertheless, the Access KP contract clearly states that care coordination requirements include "ensuring that care coordination is provided for members around all covered services and Medicaid FFS services." Colorado Access conducted an on-site review of care coordination records in September 2016 which assessed documentation in the medical record of some, but not all, care coordination requirements for a sample of seven cases. Colorado Access provided no documented analysis of results or conclusions resulting from the audit. It was unclear whether the audit of the members' records applied to the full continuum of service needs or just those under the Access KP covered services. The on-site audit also included no documented findings related to operational care coordination policies and procedures or interviews with staff, as specified in Colorado Access' CMP. Colorado Access should work with KP to clarify responsibilities for performing all care coordination responsibilities outlined in the Access KP contract.		
Required Actions: Colorado Access must enhance assessment of the comprehensive care coordination requirements delegated to the subcontractor to ensure that all care coordination requirements specified in the Access KP contract are performed by either KP or Colorado Access or collaboratively. Colorado Access should thoroughly document the analysis of results of its assessment processes and work with KP to address any gaps or challenges in performing comprehensive care coordination requirements.		
7. The Contractor certifies to the best of its knowledge and belief that its subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency. Contract: 20.C (i)	• **Employment Screening Policy NATL.HR.011** o Pages 2-6 Sec 5.1 – 5.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
8. The Contractor certifies that the subcontractor does not knowingly employ or contract with an illegal alien to perform work delegated to the subcontractor. Contract: 21.K	• **Employment Screening Policy NATL.HR.011** o Pages 2-6 Sec 5.1.3; Sections 5.1 – 5.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. Subcontractors must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. Contract: Exhibit A—3.9.1.2.1	• **AuthorizationofServices16** o Page 4: Procedure to Implement Policy	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While KP had policies and procedures for authorization of services, no evidence was provided that Colorado Access had reviewed these policies or assessed UM operational processes to determine whether or not KP was adequately following these procedures for Access KP members. Staff stated that KP's UM procedures applied only to the scope of services defined in the Access KP contract and that any out-of-network or non-covered services were authorized through the Medicaid FFS UM program. However, KP's Authorization of Services policy did not address the processes unique to Access KP members. The KP delegation agreement and Colorado Access CMP outlined numerous additional requirements related to the subcontractor's UM program; however, at the time of on-site review, Colorado Access had not conducted a review of KP for compliance with those requirements.		
Required Actions: Colorado Access must implement mechanisms to assess and maintain oversight of KP's UM procedures as well as compliance with additional UM requirements of the KP delegation agreement.		
10. The Contractor shall provide a copy of the policies regarding members' rights and responsibilities to all subcontractors and ensure that subcontractors are aware of information being provided to members. Contract: Exhibit A—4.1.1.3.8	• **Readiness Review ACC Access KP FINAL** o Page 11-13. Enrollment: 4, 5. o Page 49. Subcontracts & Delegation: 6. Bullet #4. • **FINAL-Access KP Member Guide** o Page 19. 132: Member Rights & Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
11. The Contractor shall ensure that its subcontractors do not for any reason bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member or any persons acting on a member's behalf for covered services provided pursuant to this contract. Contract: Exhibit A—6.10.2	• **Access-KP Delegation Agreement Final** o Page 27: Article VII.E. Member Held Harmless. • **KP audit tool screenshot WITH RESULTS - Claims section only** -Tool used to perform onsite chart audit of KP. Limited to claims section for clarity.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	3	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	6

Total Score ÷ Total Applicable	=	55%

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for ACC: Access KP

Review Period:	July 1, 2016—February 15, 2017
Date of Review:	March 21, 2017
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Dan Obarski, Stephanie Gillan, Megan Cheever, Jeannie Hoover

Requirements	File 1	File 2	File 3	File 4	File 5
Member	SS	KW	RC	CK	KC
Date of initial request	07/28/16	08/05/16	08/11/16	08/18/16	09/06/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	S	S	S	R
Date notice of action sent	08/08/16	08/16/16	08/18/16	08/18/16	09/12/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	11	11	7	1	6
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC	NC	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	NC	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Compliant Elements	**5**	**5**	**6**	**5**	**6**
Score (Number Compliant / Number Applicable) = %	**83%**	**83%**	**100%**	**83%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for ACC: Access KP

Requirements	File 6	File 7	File 8	File 9	File 10
Member	MC	MM	RM	MU	KD
Date of initial request	10/05/16	10/06/16	10/27/16	11/29/16	01/11/17
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
Standard (S), Expedited (E), or Retrospective (R)	S	E	E	R	E
Date notice of action sent	10/19/16	10/10/16	10/28/16	12/07/16	01/12/17
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	14	4	1	8	1
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Compliant Elements	**5**	**6**	**6**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**83%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 60	Total Compliant Elements: 56	Total Score: 93%

Notes:

File 1 (SS)—Denied due to out-of-network (Access KP members are required to receive covered services in network). Notice of action (NOA) not provided within required time frame.

File 2 (KW)—Denied due to out-of-network (Access KP members are required to receive covered services in network). NOA not provided within required time frame.

File 3 (RC)—Denied due to out-of-network (Access KP members are required to receive covered services in network).

File 4 (CK)—Denied due to medical necessity. Free-form text explanation of reason for denial difficult to understand. (Explanation included technical discussion of Hayes criteria and which criteria were not met.)

File 5 (KC)— Provider request after provision of service. Provider was not informed by member of Access KP and assumed member was traditional Medicaid. Denied due to out-of-network.

File 6 (MC)—Denied due to out-of-network (Access KP members are required to receive covered services in network). NOA not provided within required time frame.

File 7 (MM)—Denied due to not a covered service (chiropractic services). Provider requested expedited determination. NOA sent in four calendar days, but two business days.

File 8 (RM)—Denied due to out-of-network (Access KP members are required to receive covered services in network). Provider requested expedited determination,

File 9 (MU)—Provider request after provision of service. Provider assumed member was traditional Medicaid—not Access KP. Denied due to out-of-network.

File 10 (KD)—Denied due to out-of-network (Access KP members are required to receive covered services in network). Provider requested expedited determination.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Access KP**.

Table C-1—HSAG Reviewers and Access KP and Department Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Access KP Participants	**Title**
Barbara Bonner	Senior Project Manager, Colorado Access
Carlos Madrid	Senior Manager, Medicaid; Clinical Operations, KP
Dan Obarski	Director of Payment Reform, Colorado Access
Jeannie Hoover	Senior Manager, Compliance, KP
Luke Martin	Manager, Network Operations and Systems Administration, KP
Mark Learned, MD	Medical Director, Medicaid and CHP—KP/Colorado Permanente Medical Group (CPMG)
Megan Cheever	Senior Manager, Medicaid Charitable Programs, KP
Paula Whittemore	Medicaid Referral Navigator, KP
Peggy Sparacino	KP Regulatory, Medicaid
Robin Dam	Compliance Auditor, KP
Stephanie Gillan	Regulatory Coordinator, UM
Susan Pharo, MD	Medical Director, Medicaid and CHP (KP/CPMG)
Thuyloan Giang	Regulatory Manager, UM, KP
Department Observers	**Title**
Matt Lanphier	Contract Manager, HCPF

Appendix D. Corrective Action Plan Template for FY 2016–2017

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the health plan via email whether: • The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. • Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via email or the FTP site, with an email notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Step	Action
Step 6	**Documentation substantiating implementation of the plan is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for Access KP

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
5. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.5.2.1.1.	The Kaiser Permanente (KP) Medical Necessity Criteria policy stated that KP "utilizes established medical evidence such as published articles, medical research studies and published medical guidelines/criteria as the basis for authorization… to assess whether the medical services requested are appropriate for the condition and provided in the most appropriate setting." The Authorization of Services policy states that "benefits are no more restrictive in amount, duration, and scope than that used in the … State Medicaid program as indicated in state statutes and regulations and the State Plan." However, policies and procedures do not specify the medical necessity criteria outlined in the State Medicaid Plan; nor do they refer staff members to another source to obtain these criteria. Therefore, it is not apparent that UM reviewers ensure that the State-defined medical necessity criteria are applied in making all final UM determinations for Access KP members. HSAG also informed staff members on-site that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all Medical Assistance programs and included the	Colorado Access must ensure that KP updates its UM policies and procedures applicable to Access KP authorization decisions to clearly define the medical necessity criteria outlined in the State Medicaid Plan.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
	addition of EPSDT-specific criteria. Therefore, HSAG recommended that KP update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10 CCR 2505-10 8.209.4.A.3(c) Contract: Exhibit A—4.1.1.4.6	The Timeliness of UM Decision-Making and Notification policy specified that the timeline for standard authorization decisions was 10 calendar days for Access KP members. However, HSAG identified in denial record reviews that three of 10 records included notices of action noncompliant with this time frame.	Colorado Access must ensure that KP provides notices of action for standard authorization decisions within 10 calendar days from receipt of the request for service.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10 CCR 2505-10 8.209.4.A.1 Contract: Exhibit A—4.1.1.4.5.1	During on-site denial record reviews, HSAG noted that some template language included in the NOA used wording—e.g., *relevant* information, *adverse benefit determination*—that did not ensure ease of understanding or approach sixth grade reading level. HSAG found one of 10 records included information in the free-form text explanation of the *reason for denial* to be a highly technical explanation of the criteria applied, and further noted that information included the free-form text explanation of *alternatives available* may be irrelevant to Medicaid members (e.g., members may choose to pay for services or bill another insurance they may have). HSAG also observed that the *Appeal Rights* section included information that could be confusing for the member and was written in language difficult for a member to understand.	Colorado Access must ensure that KP's NOAs to Access KP members ensure ease of understanding (sixth-grade reading level where possible).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except— – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur.	KP's Timeliness of UM Decision-Making and Notification policy addressed time frames for making UM decisions for standard and expedited decisions and related extensions. Staff members stated that KP does not terminate or reduce previously approved authorizations for members. However, the policy omitted reference to other notification timeframe requirements applicable to Medicaid members, specifically: • For service authorization decisions not reached within the required time frames on the date that time frames expire. • If the Contractor extends the time frame, no later than the date the extension expires. • For denial of payment, at the time of any action affecting the claim. In addition, staff members were unable to confirm whether or not claims payment procedures were aligned with the requirement to provide an NOA to the member at the time of any action affecting the claim (i.e., denial of payment decisions).	Colorado Access must ensure that KP updates its policies and procedures to address all notification time frames applicable to Access KP members as outlined in the requirement. Colorado Access must also confirm that KP's claims payment procedures are aligned with the requirement to provide an NOA to the member at the time of denial of claim payment (excludes administrative denials).

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
○ The member has been admitted to an institution in which the Member is ineligible for Medicaid services. ○ The member's address is determined unknown based on returned mail with no forwarding address. ○ The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. ○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services.		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires, and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211*, *431.213*, and *431.214* 10 CCR 2505-10 8.209.4.A.3 Contract: Exhibit A—4.1.1.4.3, 4.1.1.4.4, and 4.1.1.4.6		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
33. The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic, and treatment components according to State and federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards and periodicity schedule. • The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under, including lead testing and immunizations. • The Contractor must implement the American Academy of Pediatrics' Bright Futures periodicity schedule. 10 CCR 2505-10 8.280.2, 8.280.8A, and 8.280.4.A (1) and (2) Contract: Exhibit A—3.7.5.2.2.	Colorado Access and KP provided no documentation of policies, procedures, or processes related to provision of EPSDT services for members ages 20 and under. Staff members stated that while EPSDT-related processes were in place within various operational components of the KP delivery system, KP had no written policies and procedures to address the provision of all required screening, diagnostic, and treatment components of the EPSDT program. Staff members also stated that KP has implemented the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, but provided no evidence to confirm that it had done so. Staff members acknowledged that it was KP's intent to develop comprehensive EPSDT policies and procedures once staff fully understood all EPSDT requirements to be addressed in the policy.	Colorado Access must ensure that KP develops and implements written policies and procedures related to comprehensive EPSDT services and requirements. Procedures should address mechanisms used by KP to implement the AAP Bright Futures periodicity schedule.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
34. The Contractor must ensure the provision of all required components of periodic health screens to EPSDT beneficiaries who request it. Screening includes: • Comprehensive health and developmental history. • Comprehensive unclothed physical examination. • Appropriate vision testing. • Appropriate hearing testing. • Appropriate laboratory tests. – As defined in the periodicity schedule. – Lead toxicity blood screening between 36 and 72 months of age if not previously tested. • Dental screening services, including an assessment of mouth, oral cavity, and teeth; and referral to a dentist for children by 1 year of age or at the eruption of the first tooth. • Developmental screening to determine whether a child's emotional and developmental processes fall within a benchmarked range according to the child's age group and cultural background. Screening includes self-care skills, gross and fine motor development, communication skills or	Staff members stated that KP has defined protocols within the Kaiser electronic health record that address the components of periodic health screens outlined in the requirement. However, KP provided no documentation or evidence to confirm that it had done so.	Colorado Access must ensure that KP provides all required components of periodic health screens to EPSDT beneficiaries.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
language development, social-emotional development, cognitive skills, and appropriate mental/behavioral health screening. *42 CFR 441.56 (b) (i)–(vi) and 441.59 (b)* 10 CCR 2505-10 8.280.8.C and 8.280.4.A (3)(a–d) Contract: Exhibit A—3.7.5.2.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
35. The Contractor must provide diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any EPSDT screening and diagnostic procedure—even if the services are not included in the plan—including: • Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids. • Dental care at as early an age as necessary for relief of pain and infections, restoration of teeth, and maintenance of dental health. • Appropriate immunizations. (If determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e–g) and 8.280.4.C (3) Contract: Exhibit A—3.7.5.2.2	KP's network or primary care and specialist providers and ancillary services appeared to provide many of the diagnostic and treatment services required as a result of EPSDT screenings, even if the services are not covered under the Access KP Plan. Staff members stated that primary care practitioners make referrals as needed within the KP network and then determine whether the services are billed to the Access KP Plan or Medicaid FFS. However, KP provided no documentation of procedures or other processes which address provision of diagnostic and treatment services identified through EPSDT screenings—even if not covered in the plan.	Colorado Access must ensure that KP has policies or procedures to address provision of diagnostic and treatment services needed as a result of EPSDT screening, including vision services, dental services, and immunizations. Colorado Access must also ensure that members receive or are referred to EPSDT-related diagnosis and treatment services not covered under the Access KP contract.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
36. A referral from the member's primary care physician may be required for EPSDT-related care provided by anyone other than the primary care physician. • Members may self-refer for routine vision, dental, hearing, or mental health services; or family planning services. • Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing, and pharmaceuticals. 10 CCR 2505-10 8.280.6 and 8.280.7 Contract: Exhibit A—3.7.5.2.2	The Health First Colorado member handbook states that members do not need approval for routine hearing, vision, dental, mental health, or family planning services. The Access KP member guide lists many EPSDT-related services—including dental services, home health services, hearing services, home health services, private duty nursing, prescription drugs and mental health services—as wraparound benefits excluded from the Access KP plan but which may be provided through Health First Colorado (Medicaid FFS). The guide stated that no referral is needed for wraparound services; however, the Health First Colorado member handbook listed some of these benefits as requiring prior authorization. Staff members stated that some services not covered by Access KP may be authorized and provided within the KP delivery system and would be billed to Medicaid FFS. Staff also stated that providers obtained authorization through the Medicaid FFS system for services outside the scope of the Access KP contract (i.e., Medicaid FFS) or referrals out of network. In the absence of a policy focused on provision of EPSDT services, it was unclear whether KP providers were responsible for obtaining authorization for EPSDT-related services not covered under the Access KP plan yet provided within the KP network; seeking authorization from Medicaid FFS for	Colorado Access should ensure that KP develops EPSDT policies and procedures that clearly outline the requirements and provider expectations related to referrals and authorizations for EPSDT-related care in or out of network.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
	wraparound benefits (defined as services not covered under the Access KP plan), some of which included EPSDT-related services; and procedures for seeking authorization through either KP or Medicaid FFS, as appropriate.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
37. The Contractor defines "medical necessity for EPSDT services" as: • A service that is found to be an equally effective treatment among other less conservative or more costly treatment options, and • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all.	KP provided no documentation that addressed the medical necessity criteria for EPSDT services and no evidence that UM authorization processes incorporate the "medical necessity" definition specific to EPSDT. HSAG noted that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 and 8.076.1.8.1 (effective August 30, 2016)—clarifies EPSDT-specific medical necessity criteria. Therefore, HSAG recommends that KP refer to the CCR and update the definition of "medical necessity" for EPSDT services accordingly.	Colorado Access must ensure that KP policies and procedures incorporate the definition of "medical necessity" for EPSDT services as outlined in the State Medicaid Plan.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: • The service is medically necessary. • The service is in accordance with generally accepted standards of medical practice. • The service is clinically appropriate in terms of type, frequency, extent, and duration. • The service provides a safe environment or situation for the child. • The service is not for the convenience of the caregiver. • The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1 and 8.280.4.E Contract: Exhibit A—1.1.1.24		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
38. The Contractor ensures provision of all required components of periodic health screens through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) Contract: Exhibit A—3.7.5.2.2	While staff members stated that KP had various operational processes in place to ensure provision of periodic health screens by providers, neither Colorado Access nor KP provided evidence of systematic communications with network providers regarding the Department's EPSDT requirements, including provider-specific responsibilities related to EPSDT requirements.	Colorado Access must ensure that Access KP providers receive systematic—i.e., regular and periodic—communications regarding the Department's EPSDT requirements.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
4. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Contract: Exhibit A—3.7.3.5	The KP provider network offers Access KP members both the primary care and specialist physicians employed by Colorado Permanente Medical Group and approximately 2,000 additional contracted specialist providers. Staff members stated that practitioners make referrals to specialists within the KP provider network as needed to meet the needs of the member. The KP integrated provider system and additional availability of numerous types of specialists within the external contracted network appear to provide sufficient ongoing access to specialists for members with special healthcare needs. Staff members stated that Access KP UM staff approve all referrals within the KP network, whether billed under the capitated Access KP contract or to Medicaid FFS. However, because Access KP members are required to have a referral to see a specialist, Colorado Access should ensure that KP referral or UM policies and procedures clearly specify that members with special healthcare needs (who use specialists frequently) are allowed to maintain these types of specialists as PCPs or are allowed direct access or standing referrals to specialists.	Colorado Access must ensure that Access KP policies and procedures specify that persons with special healthcare needs who use specialists frequently are allowed to maintain these types of specialists as PCPs or be allowed direct access or standing referrals to specialists.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
14. If the screening provider is not licensed or equipped to render necessary EPSDT-related treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. • The Contractor advises participating providers of EPSDT services available through other entities. 10 CCR 2505-10 8.280.4.C.2 Contract: Exhibit A—3.5.4.1.2	Staff members described referral processes commonly applied to all members within the KP provider network, and the KP Medical Director communicated a general overview of the KP pediatric quality assurance program; however, KP did not have EPSDT-specific policies and procedures to address the requirement that providers refer members for further EPSDT-related diagnosis and treatment either to an appropriate practitioner or to Healthy Communities. KP also did not provide evidence of informing providers of EPSDT-related services available through other entities or of information pertaining to Healthy Communities.	Colorado Access must ensure that KP addresses EPSDT diagnosis and treatment referral requirements, educates providers about Healthy Communities, and advises providers of EPSDT services available through other entities.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
1. The Contractor oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor including: • The requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract. *42 CFR 438.230(a)(1)* *Requirement to be updated 7/2017—see appendix)* Contract: 19.A; Exhibit A—3.1.3.5 and 3.1.3.5.1	The KP delegation agreement specified that the following functions were delegated to KP: care management, communications, finance, claims payment, data management/information technology, member enrollment, utilization management, appeals and grievances, network management, and provision of primary and specialty services. The Department's contract with Colorado Access specifies that Colorado Access is accountable for all 42 CFR Part 438 requirements related to these delegated activities. The Access KP CMP outlined the components of Colorado Access oversight and audit of contract deliverables, which primarily included review of defined deliverable reports from KP to Colorado Access, an annual on-site review for claims verification and review of a sample of care coordination files, and a delegation audit—not yet designed or implemented at the time of HSAG review—consisting of a detailed review of "deliverables." Colorado Access submitted no documents which provided evidence that it had implemented or intended to implement oversight or audit of KP's operational processes related to 42 CFR Part 438. The federal managed care requirements specified in 42 CFR Part 438 include extensive policy, procedure, and operational process requirements; therefore, Colorado Access must include in its CMP a mechanism to ensure	Colorado Access must define and implement mechanisms to maintain oversight and accountability for requirements of CFR 42 Part 438 applicable to the services and activities delegated to the subcontractor.

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
	compliance with the requirements of 42 CFR Part 438 appropriate to the service or activity delegated to the subcontractor and/or must demonstrate accountability for those processes within Colorado Access operations. HSAG recommends that Colorado Access consider designing the proposed delegation audit to comprehensively address all applicable federal requirements related to the subcontractor's delegated activities.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
4. The Contractor monitors the subcontractor's performance on an ongoing basis and subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. Per the Kaiser Delegation Agreement, the delegate is responsible for all of the following: • Care management • Communications • Finance • Claims payment • Data management/information technology • Member enrollment • Utilization management • Appeals and grievances • Network management • Provision of primary and specialty services *42 CFR 438.230(b)(3)* *Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.1.3.5.4 Kaiser Delegation Agreement—II.A	Colorado Access had defined an Access KP CMP which stated that Colorado Access would perform oversight of the Access KP contract requirements, including monitoring of the subcontractor's delegated responsibilities, through annual on-site visits; regular monitoring of deliverables (reports specified); communications with members; medical records; claims, grievances and appeals; secret shopper calls; other reports; and a delegation audit every six months, consisting of a detailed review of KP's delivery of each "deliverable" (not defined). Colorado Access and KP had a joint operating group that met weekly to discuss the implementation of the structural components of the contract. Colorado Access and KP also jointly participated in the Performance Improvement Advisory Committee (PIAC), designated as the oversight mechanism for outcome measurement goals of the Access KP pilot program. HSAG's findings related to implementation of ongoing and formal review of the subcontractor's performance to date were as follows: • Colorado Access had developed a deliverable tracking schedule to monitor receipt of deliverables from KP and reporting of deliverable reports to the Department. At the time of review, Colorado Access had documented receipt of numerous deliverable reports. Although	Colorado Access must: • Ensure that its oversight and monitoring of the subcontractor include assessment of all areas of responsibility delegated to KP as well as thorough assessment of the detailed contract requirements. • Document results of all oversight activities and KP deliverables in a manner that reflects analysis of findings and related qualitative conclusions. • Design and implement the delegation audit (due January 2017) timely, as defined in the CMP.

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
	staff members stated that Colorado Access reviewed each deliverable report to compare to contract requirements, Colorado Access did not document a qualitative assessment of the reports or any conclusions that may have resulted from such. Therefore, documentation of using the reports for oversight of the subcontractor's performance was not evident. • Colorado Access conducted one on-site review in September 2016, which consisted of an encounters/claims validation (30 records) and a medical record review (seven records) of advance directives, many elements of care coordination, and interpreter services. Colorado Access submitted a corrective action plan to KP. However, Colorado Access provided no evidence of qualitative analysis of findings of the audit nor evidence that KP's operational processes (e.g., policies and procedures, staff interviews) were evaluated, as stated in the CMP. • At the time of on-site review, the delegation audit outlined in the CMP (due January 2017) had not been designed, conducted, or scheduled. Therefore, Colorado Access could provide no evidence of the components of the	

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
	delegation audit intended to perform a detailed formal review of the subcontractor's "deliverables." • The CMP failed to address oversight processes related to every area of responsibility (such as utilization management) delegated to the subcontractor in the KP delegation agreement. In addition, the CMP did not clearly define processes for evaluation of KP's operational processes related to each category of delegated activity to ensure that the contact requirements outlined in Appendix B of the CMP were met. • Due to the fact that most functions and requirements of the Access KP contract were delegated, it would appear that adequate oversight and monitoring by Colorado Access would require extensive resources. It was not apparent to HSAG which Colorado Access organizational resources were engaged in the oversight and monitoring processes. Colorado Access should reassess its subcontractor monitoring processes to ensure that processes comprehensively address all subcontracted activities, mechanisms defined are implemented, and results of all monitoring activities are analyzed and documented.	

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

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action. *42 CFR 438.230(b)(4)* *Requirement to be updated 7/2017—see appendix)* Contract: Exhibit A—3.1.3.5.5	The KP delegation agreement specified that the failure of the delegate to perform any of its material obligations, in whole or in part or in a timely manner, constitutes a breach, and that KP has 30 days to cure such breach. The Access KP CMP addressed corrective actions in isolated areas of the document, but was unclear regarding expectations for corrective action and related time frames overall. Staff members stated that, with the exception of identified individual member issues, time frames and expectations for corrective actions were negotiable based on other operational priorities of the subcontractor. Agendas of the joint operating group weekly meetings indicated that various issues of contract implementation were being addressed ongoing. The minutes of the PIAC reflected no review or oversight of KP deliverables, no audit activities, and no corrective actions implemented to date. Colorado Access provided documentation of an example of one formal KP corrective action resulting from on-site audit of KPs care coordination files. KPs corrective action plan indicated that KP's corrective actions would be implemented nine to 11 months from the date of Colorado Access' required actions.	Colorado Access must review its CMP and processes to ensure that the subcontractor's performance is adequately analyzed and that all areas of potential deficiency are assessed and corrective actions implemented in a timely manner. Colorado Access should consider more clearly addressing in its CMP expectations for corrective actions.

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

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
6. In the event that the Contractor allows a subcontractor to perform any care coordination activities, the agreement with that subcontractor shall comply with all applicable requirements of the contract (with the Department). Applicable care coordination requirements include: • Providing staff necessary to ensure that care coordination functions are performed. • Maintaining a toll-free telephone line that members may call regarding care coordination issues. • Ensuring that care coordination is provided for members around all covered services and Medicaid FFS services. • Defining care coordination as the process of identifying, screening, and assessing members' needs (medical and nonmedical); identifying of and referring to appropriate services; and coordinating and monitoring of individualized care plans. • Ensuring care coordination that reflects the needs of members to achieve their desired health outcomes in an efficient and responsible	The Access KP delegation agreement assigned responsibility for all care management activities to KP. Although the agreement outlined many care coordination requirements reflected in the Access KP contract, it did not specifically align with the language of the requirements in the contract (i.e., the agreement outlined the components of the formal system of care defined in the Colorado Access RCCO contract rather than the requirements specified in the Access KP contract). The agreement also failed to include several requirements of the Access KP contract, such as requirements for maintaining sufficient staffing to ensure that care coordination requirements are performed, maintaining a toll-free number for members to call related to care coordination issues, and documenting all elements of the formal system of care coordination in the care plan. Colorado Access had obtained and reviewed KP's *Formal System of Care Coordination*, but provided no documentation of Colorado Access' review and assessment of the sufficiency of the *Formal System of Care Coordination* in relation to Access KP contract requirements. Discussions during the on-site interview indicated that KP was experiencing difficulty performing responsibilities for care coordination of the full continuum of services for members because the Access KP contract is	Colorado Access must enhance assessment of the comprehensive care coordination requirements delegated to the subcontractor to ensure that all care coordination requirements specified in the Access KP contract are performed by either KP or Colorado Access or collaboratively. Colorado Access should thoroughly document the analysis of results of its assessment processes and work with KP to address any gaps or challenges in performing comprehensive care coordination requirements.

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
manner, including documentation of the member's desired health outcomes and identification of other members of that member's care coordination team in the care coordination care plan. • Assessing current care coordination services provided to members to determine if the providers involved in a member's care are providing necessary care coordination services and which care coordination services are insufficient or not provided. • Providing all care coordination services not provided by another source. • Working with providers responsible for the member's care to develop a plan for regular communication with the person(s) responsible for the member's care coordination. • Reasonably ensuring that all care coordination services, including those provided by other individuals or entities, meet the needs of the member. • Ensuring that the care coordination team has access to an integrated care plan across provider and community organizations, including a comprehensive psychosocial	limited to a defined set of ambulatory services delivered only within the KP network. In addition, staff members stated that KP does not have access to data related to the FFS elements of the continuum of care (e.g., SDAC data). Nevertheless, the Access KP contract clearly states that care coordination requirements include "ensuring that care coordination is provided for members around all covered services and Medicaid FFS services." Colorado Access conducted an on-site review of care coordination records in September 2016 which assessed documentation in the medical record of some, but not all, care coordination requirements for a sample of seven cases. Colorado Access provided no documented analysis of results or conclusions resulting from the audit. It was unclear whether the audit of the members' records applied to the full continuum of service needs or just those under the Access KP covered services. The on-site audit also included no documented findings related to operational care coordination policies and procedures or interviews with staff, as specified in Colorado Access' CMP. Colorado Access should work with KP to clarify responsibilities for performing all care coordination responsibilities outlined in the Access KP contract.	

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
assessment and a multidimensional plan addressing social, physical, and behavioral health needs. • Developing a formal system of care coordination for its members. All elements of the formal system of care coordination shall be documented in the care plan, including: – Assessing the member's health and health behavior risks and medical and non-medical needs, determining if a care plan exists, and creating a care plan if needed. – Linking members both to medical services and to non-medical, community-based services such as child care, food assistance, services supporting elders, housing, utilities assistance, and other non-medical supports as necessary. – Providing assistance during care transitions from hospitals or other care institutions to home or community-based settings or during other transitions such as the transition from children's health services to adult health services or from hospital or		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
home care to care in a nursing facility. – Providing or working with community-based organizations to arrange for an individual to act as a care coordinator for each member during any transitions and communicating with every member to which they are assigned, once while the member is in the hospital and again within 48 hours of that member's discharge. – Providing solutions to problems encountered by providers or members in the provision or receipt of care. – Following up with members to assess whether the member has received needed services and is on track to reach their desired health outcomes. – Providing care coordination activities linguistically appropriate to the member and consistent with the member's cultural beliefs and values. – Providing care coordination responsive to the needs of special populations (e.g., physically or		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
developmentally disabled, members with HIV, the aged). – Providing care coordination that aims to keep members out of a medical facility or institutional setting and to provide care in the member's community or home to the greatest extent possible. Contract: Exhibit A—1.1.1.5, 3.3.5.1.2, and 3.7.2.1 through 3.7.2.4.1		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
9. Subcontractors must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. Contract: Exhibit A—3.9.1.2.1	While KP had policies and procedures for authorization of services, no evidence was provided that Colorado Access had reviewed these policies or assessed UM operational processes to determine whether or not KP was adequately following these procedures for Access KP members. Staff stated that KP's UM procedures applied only to the scope of services defined in the Access KP contract and that any out-of-network or non-covered services were authorized through the Medicaid FFS UM program. However, KP's Authorization of Services policy did not address the processes unique to Access KP members. The KP delegation agreement and Colorado Access CMP outlined numerous additional requirements related to the subcontractor's UM program; however, at the time of on-site review, Colorado Access had not conducted a review of KP for compliance with those requirements.	Colorado Access must implement mechanisms to assess and maintain oversight of KP's UM procedures as well as compliance with additional UM requirements of the KP delegation agreement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to Medicaid service and claims denials and notices of action. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2016–2017 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.