CHP+

Child Health Plan *Plus*

# Fiscal Year 2023–2024 Compliance Review Report

*for*

# Kaiser Permanente

*February 2024*

*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

## Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (HSAG) assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Kaiser Permanente (Kaiser) demonstrated improvement in one standard compared with the prior review. Kaiser showed strong understanding and compliance with the Provider Selection and Program Integrity and Quality Assessment and Performance Improvement standards. Kaiser showed moderate compliance with the other two standards under review, as HSAG identified opportunities for improvement and required actions in each of these areas.

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

**Table 1-1—Summary of Scores for the Standards**

| Standard | # of Elements | # of Applicable Elements | # Met | # Partially Met | # Not Met | # Not Applicable | Score* (% of Met Elements) |
|---|---|---|---|---|---|---|---|
| V. Member Information Requirements | 21 | 21 | 18 | 3 | 0 | 0 | 86%v |
| VII. Provider Selection and Program Integrity | 16 | 15 | 15 | 0 | 0 | 1 | 100%^ |
| IX. Subcontractual Relationships and Delegation | 4 | 4 | 3 | 1 | 0 | 0 | 75%~ |
| X. Quality Assessment and Performance Improvement (QAPI)** | 17 | 17 | 17 | 0 | 0 | 0 | 100%~ |
| **Totals** | **58** | **57** | **53** | **4** | **0** | **1** | **93%** |

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

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

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

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

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

# Standard V—Member Information Requirements

## *Evidence of Compliance and Strengths*

Kaiser used a process to provide member information to members during their initial enrollment as well as when requested, at no cost, in English and prevalent non-English languages. Member materials were provided in alternative formats such as being printed in large font size, braille, and audio. Kaiser staff members reported that customer service representatives assist members by providing member materials in digital format or by mail. Customer service representatives were trained on member benefits via onboarding, periodic training, and real-time communications. Member materials that were sent to the member upon enrollment consisted of a member enrollment letter and a new member postcard, which directed members to the current member handbook, hosted on Kaiser's website.

Kaiser described in detail how member materials were reviewed and tested for reading level and compliance with Section 508 of the Rehabilitation Act. Most member materials were tested annually, while the provider directory was tested monthly, and the website was tested more frequently. Kaiser submitted a CHP+ member materials review procedure that included the titles of the materials, how often the materials were reviewed and updated, who oversaw the reviews, and the points of contact for the review. The procedure also included a list of dates indicating when the materials were last reviewed. When asked about how errors were found and addressed, Kaiser staff members described the process to identify errors, communicate with points of contact, and how they quickly resolved the errors. Kaiser reported having access to consultants in the Accessibility Team when further assistance was needed. HSAG tested the accessibility of the content located on Kaiser's website using the Web accessibility evaluation tool (WAVE) and found a low number of errors.

Staff members reported during the interview that provider terminations were tracked between two departments at Kaiser. Kaiser submitted a member notification of provider terminations document as evidence of how staff members understand the process of the terminations and the requirement for Kaiser to make a good faith effort to provide written notice of termination of a contracted provider at least 30 calendar days before the effective date or within 15 working days of receipt of a notice to each member who would be affected by the change.

## *Opportunities for Improvement and Recommendations*

Kaiser showed improvements to the member materials reading level and described how improvements continue to be addressed. HSAG encourages Kaiser to continue working through challenges in member materials to ensure the language is at or around sixth-grade reading level. Additionally, to improve the readability of critical member materials, HSAG strongly encourages Kaiser to implement a mechanism for member testing and feedback using the Department of Health Care Policy & Financing's (the Department's) member experience committee.

Information regarding sign language interpretation, audio, and other language assistance was located in the nondiscrimination section of the provider directory and detailed how to obtain these services. HSAG recommends relocating the language regarding sign language interpretation, audio, and other language assistance from the nondiscrimination section of the provider directory to a separate location, as it could be lost in the provider directory.

### *Required Actions*

Kaiser submitted several forms of written information that a member may obtain that included complete taglines. The taglines in the provider directory portable document format (PDF) and the new member postcard did not include how to request auxiliary aids and services. Kaiser must revise the provider directory PDF and the new member postcard taglines to describe how the member can request auxiliary aids and services.

Kaiser was inconsistent across several documents when describing the time frame required for sending a member requested information in paper form. Kaiser must revise the desktop procedure, literature report procedure, and "how to order literature" process to be consistent with the time frame in the requirement.

The provider directory on Kaiser's website included the ability to search, download, and print. The provider directory allowed members to use filters to search for providers with accommodations for people with physical disabilities. During the interview, however, staff members could not convey how this provider information was captured to ensure its accuracy. Kaiser must develop a process to conduct outreach or other forms of communication with the provider to ensure that the information on the website's provider directory is up to date and accurate.

## Standard VII—Provider Selection and Program Integrity

### *Evidence of Compliance and Strengths*

Kaiser described a thorough provider selection and retention process, which included ongoing analysis of provider or specialist recruitment need, used multiple recruitment modalities, used a detailed vetting process that aligns with National Committee for Quality Assurance (NCQA) guidelines, and included a comprehensive onboarding process which was described as taking three years to fully complete. Kaiser's compliance team was described as layered and included national, regional, and local compliance offices that work in conjunction with other departments to prevent, detect, and respond to compliance risks. Important compliance responsibilities were divided among revenue, security, and health plan operations, with the regional compliance officer reporting directly to the chief compliance officer and the regional president.

Kaiser submitted documents that outlined its compliance program in detail and were supported by policies, procedures, and a description of other regular reports. Policies, procedures, and work plans were operationalized through quarterly executive and regional compliance committee meetings, and

annual compliance trainings, for example. Committee participants included key leaders to provide diverse perspectives and an opportunity for feedback about trends.

Kaiser staff members reported that compliance activities focused on deploying key information in a centralized manner. No major software changes were reported. Kaiser emphasized the development of a "open" culture related to compliance efforts.

### *Opportunities for Improvement and Recommendations*

HSAG identified no recommendations.

### *Required Actions*

HSAG identified no required actions.

## Standard IX—Subcontractual Relationships and Delegation

### *Evidence of Compliance and Strengths*

Kaiser submitted several contracts for review, including a contract template. Kaiser reported having agreements for credentialing with SCL Health Medical Group, HealthONE, Centura Health, and University Physicians, Inc. (UPI). Pharmacy services were performed by MedImpact, and postcard printing was completed by OneTouchPoint. Kaiser conducted most credentialing and administrative tasks internally.

During the selection of vendors process, an initial delegation audit was conducted. Once the delegation audit was completed, Kaiser would generate a letter to the vendor with the final decision. Kaiser performed annual delegation audits on current, existing vendors. Kaiser staff members reported that both processes were similar, and vendors were reviewed for the same elements during both the initial and annual audit. Current vendors were overseen through an oversight committee that met quarterly. Topics that were discussed by the oversight committee consisted of credentialing, provider experience, and vendor issues. Kaiser staff members would conduct outreach to vendors if more sensitive issues arose that would need to be addressed immediately. In the past, Kaiser reported placing some vendors on corrective action plans (CAPs) when their performance did not meet Kaiser's expectations, but staff members were not aware of any vendor terminations during the review period.

### *Opportunities for Improvement and Recommendations*

HSAG identified no recommendations.

### Required Actions

Kaiser included all federally required language in the contract template and most of the delegated agreements that it submitted as evidence. The agreement with UPI, however, did not include the required language regarding the right of the State, the Centers for Medicare & Medicaid Services (CMS), or the U.S. Department of Health and Human Services (HHS) Inspector General to inspect, evaluate, and audit the subcontractor at any time if there is a reasonable probability of fraud or similar risk. Kaiser must update the agreement between Kaiser and UPI to include the required language. To show evidence of completion, Kaiser must show an approved amendment.

## Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

### Evidence of Compliance and Strengths

Kaiser submitted evidence of a comprehensive and layered quality program that hosted many activities and showed active involvement throughout the organization. During the interview, Kaiser provided a high-level overview of its national and regional quality involvement, its diverse quality committees, and how they intersect. The documents submitted included a quality program description, a workplan, and an evaluation as the key "trilogy" of documents that were reviewed and approved by senior leadership through an extensively structured set of workgroups and committees. During the interview, clinical staff members spoke in-depth about social determinants of health (SDOH), performance improvement projects (PIPs), and the intensive work that has gone into interventions and the SDOH dashboard, which outlined areas of importance in the PIP study. Extensive reports were submitted that demonstrated overutilization monitoring and underutilization efforts, which included monitoring for gaps in care and a recently launched text messaging system that reminds parents of members in age-based cohorts to schedule well-visits.

The Kaiser clinical practice guideline lead discussed the process for reviewing, approving, maintaining, and sharing Kaiser clinical practice guidelines, which were stored in its clinical library and updated on a regular basis. In addition to the provider-facing materials, Kaiser also maintained member-facing materials that effectively outlined care standards for members.

Kaiser diagramed its health information system in its data integration flowchart as a centralized system called Kaiser Permanente Health Connect. The system integrated the Kaiser platform and other timely data sources, which fed into the Epic system. The data warehouse also provided what clinical staff members described as a usable medium for visualizing patient information. The claims processing workflow addressed how the automated software identified any issues such as data formatting errors, which would be sent back to the provider to address, or larger issues such as extremely high-cost claims, which required additional handling, review, and approval from claims staff members before the claim could be further processed in the system.

Members' perception of satisfaction with their access to and the quality of services was monitored through numerous avenues. Efforts were further evidenced through documents within the credentialing standard where Kaiser ensured that organizational providers also deployed member satisfaction measures on a regular basis.

## Opportunities for Improvement and Recommendations

HSAG identified no recommendations.

## Required Actions

HSAG identified no required actions.

# 3. Background and Overview

## Background

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in December 2020 and February 2023. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

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

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for Kaiser. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, CHP + MCO, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D contains a detailed description of HSAG's compliance review activities consistent with the CMS External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[3-1]

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 8, 2023.

## Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

## Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix D contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2023–2024 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; and Standard XII—Enrollment and Disenrollment.

## Objective of the Compliance Review

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

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

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

## FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with Kaiser until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

## Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, Kaiser was required to complete four required actions:

- Edit its member handbook to include the complete definition of "medically necessary."
- Enhance its monitoring procedures to ensure standard authorization decisions are made as expeditiously as required and do not exceed 10 calendar days. Update its policy to address the factors considered in expediting the decision and the notice to the member, including instances that could jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Expedite authorization decisions when appropriate.
- Update its policies and procedures to address the exceptions to the 10-day notice required before the reduction, suspension, or termination of a previously authorized CHP+-covered service, and should either state that Kaiser does not deny previously authorized services (as recommended during the FY 2019–2020 review) or provide a process for doing so that includes federal and State requirements.
- Revise its *Coverage of Emergency Services and Post-Stabilization Care Policy ID #: 6891-03* to state that the attending emergency physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that the determination is binding for Kaiser, which is responsible for coverage and payment.

Related to Standard II—Adequate Capacity and Availability of Services, HSAG identified no required actions.

Related to Standard VI—Grievance and Appeal Systems, Kaiser was required to complete nine required actions:

- Make changes to its member handbook to state that with the member's written consent, a provider or authorized representative may file a grievance.
- Update its policies, procedures, and the member handbook to include providing member assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
- Revise the member handbook to state that the grievance acknowledgment letter will be sent within two working days.
- Make changes to the member handbook to state that the appeal acknowledgment letter will be sent within two working days.
- Update its policies and procedures to clarify that parties to an appeal may be the member, the member's representative, or the legal representative of a deceased member's estate.
- Revise the member handbook to clarify that for standard appeals, Kaiser will provide the resolution notice within 10 working days from the day Kaiser receives the standard appeal.
- Update its policies and procedures to include the requirement that the Contractor shows (to the satisfaction of the Department, upon request) that there is a need for additional information and that the delay is in the member's interest.
- Edit the member handbook to inform the member that within two calendar days, Kaiser will give the member written notice of the reason for the delay and to inform the member of the right to file a grievance if the member disagrees with that decision. The member handbook must also state that Kaiser will resolve the appeal as expeditiously as the member's health condition requires and no later than the date that the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).
- Revise its member handbook and the CHP Appeal Rights document to state that the parties to the State fair hearing include the Contractor, the member and the member's representative, or the representative of a deceased member's estate.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions.

## Summary of Corrective Action/Document Review

Kaiser submitted a proposed CAP in February 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to Kaiser. Kaiser submitted final documentation and completed the CAP in June 2023.

## Summary of Continued Required Actions

Kaiser successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members.<br><br>*Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.*<br><br>*42 CFR 438.10(c)(1)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.2.5 and 7.2.7.5 | Important member documents and information are posted online at: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/<br><br>Documents posted online are tested for accessibility and reviewed for clear and simple content:<br>- **MCP CHP Member Materials Review-procedure** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan.<br><br>*42 CFR 438.10(c)(7)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5 | Newly enrolled CHP+ members receive the below postcard about how to access the 'CHP+ Evidence of Coverage', also known as the Member Handbook:<br>- **V KPCO_CHP_PC_10062022**<br>- **V CHP+ Desktop Procedures_2023.09.21,** page 2<br><br>Also, each month KP mails new enrollees a 'CHP+ New Member Postcard'. This postcard informs members about important member documents and that information is online or can be printed by calling Member Services:<br>- **Chp+New-Member-Postca_COM_CO-DB_2023_PC_EngSp-r2a-ja_COEdits** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | The 'CHP+ Evidence of Coverage', also known as the Member Handbook explains member benefits and other plan details:<br>- **CHP_EOC_updates for 7.1.2023_Final** | |
| 3. For consistency in the information provided to members, the Contractor uses the following as developed by the State:<br>• Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.<br>• Model member handbooks and member notices.<br>*42 CFR 438.10(c)(4)*<br>CHP+ Contract Amendment 2: Exhibit B2—3.2 and 7.2.7.5 | **CHP_EOC_updates for 7.1.2023_Final**<br>Appeal, page 99<br>co-payment, page 100<br>durable medical equipment, page 100<br>emergency medical condition, page 100<br>emergency medical transportation, page 100<br>emergency room care, see below emergency services<br>emergency services, page 101 and 58<br>excluded services, page 101<br>grievance, page 101<br>habilitation services and devices, page 101<br>health insurance, page 101<br>home health care, page 102<br>hospice services, page 102<br>hospitalization, page 102<br>hospital outpatient care, see outpatient care page 104<br>medically necessary, page 102-103<br>network, page 103<br>non-participating provider, see 'non-network Facility' and 'Non-network Provider' page 104<br>physician services, page 105 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | plan, page 10<br>preauthorization, page 105<br>participating provider, see 'network facility' and 'network provider' page 103<br>premium, not applicable<br>prescription drug coverage, page 50<br>prescription drugs, page 105<br>primary care physician, page 105<br>primary care provider, page 105<br>provider, see 'Doctors' page 27<br>rehabilitation services and devices, page 106<br>skilled nursing care, page 106<br>specialist, page 106<br>urgent care, page 107<br>Note: not all terms are defined by the state<br><br>Here is an example of a recent CHP+ Member communication about updating contact information:<br>- **V 2022_05_03_UYA_Flyer_Digital_ English_ EC_v2_RESIZED**<br>- **V 2022_05_03_UYA_Flyer_Digital_ Spanish_ EC_v2_RESIZED** | |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost.<br>• Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.<br>• All written materials for members must:<br>– Use easily understood language and format.<br>– Use a font size no smaller than 12 point.<br>– Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency.<br>– Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.<br>*42 CFR 438.10(d)(2-3) and (d)(6)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7 | **CHP_EOC_updates for 7.1.2023_Final**,<br>- Other Languages and Formats, page 5<br>**chp-provider-directory-august-2023-co-en**<br>- Help in your language, page 2 (also on page 181)<br>**V H0630_22042_C CPMG PCP retire and term letter template**<br>- Notice of nondiscrimination, page 3<br>**Resolutions for Non-Medicare Process Levels**<br>- Language Assistance and Resolution Requirements, page 1<br>- Readability requirements, page 10<br>**Medicaid GRV Res_0.18_template**<br>- Help in your language, page 7<br>**Medicaid Adverse_0.20_template**<br>- Help in your language, page 10-11<br>**V CHP Benefit Denial Letter Example**,<br>- Notice of nondiscrimination, page 7<br>**V CHP NABD Letter Example**<br>- Notice of nondiscrimination, page 7<br><br>Note: KP uses NCQA guidelines for creating denial letters which requires that the denial reasons and notices are written in a language that is easy for members to understand. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:**<br>Kaiser submitted several forms of written information that the member may obtain that included complete taglines. The taglines in the provider directory PDF and the new member postcard did not include how to request auxiliary aids and services. | | |
| **Required Actions:**<br>Kaiser must revise the provider directory PDF and the new member postcard to describe how the member can request auxiliary aids and services. | | |
| 5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:<br>• The format is readily accessible (see definition of readily accessible above).<br>• The information is placed in a website location that is prominent and readily accessible.<br>• The information can be electronically retained and printed.<br>• The information complies with content and language requirements.<br>• The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days.<br>*42 CFR 438.10(c)(6)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.12.1.1-5 | Important member documents and information are posted online at:<br>https://charitablehealth.kaiserpermanente.org/colorado/member-resources/<br>- This website should also appear by searching for "KP Colorado CHP".<br>- All KP CHP member documents are posted on the 'Resources' page.<br>- Documents online can be saved or printed.<br><br>Members can also call KP Member Services to request a printed copy of CHP+ member documents:<br>- **V How to Order Literature CHATS**, Page 4 describes that documents will be mailed within 3 business days<br><br>Kaiser monitors the timeliness of requests to print member materials: | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | - **MCP CHP Literature Report-procedure 6.23.2021**<br>- **MCP CHP Literature Report - April CHATs report – Printed EOC requests**<br><br>CHP+ Member materials that are updated and posted on the website are reviewed for accessibility and 'clear and simple' language:<br>- **MCP CHP Member Materials Review-procedure** | |
| **Findings:**<br>Kaiser included a desktop procedure, literature report procedure, and "how to order literature" process as evidence. Each document used inconsistent language to describe the time frame required for sending the member requested information in paper form. | | |
| **Required Actions:**<br>Kaiser must revise the desktop procedure, literature report procedure, and "how to order literature" process to be consistent with the time frame in the requirement. | | |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 6. The Contractor makes available to members in electronic or paper form information about its formulary:<br>• Which medications are covered (both generic and name brand).<br>• What tier each medication is on.<br>• Formulary drug list must be available on the Contractor's website in a machine readable file and format.<br>*42 CFR 438.10(h)(4)(i)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1.2-3 | **chp-plus-formulary-co-en**<br>- Covered drugs are listed in the formulary tables and both BRAND and generic drugs are listed. Also there is a column for Tier Levels.<br><br>The CHP+ formulary is posted online at: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/<br><br>Here is where the CHP+ Machine Readable files are posted, under 'Colorado': Technical Information (kaiserpermanente.org) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them.<br>• This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.<br>*42 CFR 438.10(d)(4)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.2.6.2, 7.2.6.4, and 7.2.6.5 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Other language and formats, page 5-6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 8. The Contractor notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and auxiliary aids and services are available upon request at no cost for members with disabilities, and how to access them.<br>*42 CFR 438.10(d)(5)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.2.6.4.1-3 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Other language and formats, page 5-6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment.<br>*42 CFR 438.10(g)(1)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1 | Newly enrolled CHP+ members receive the below postcard about how to access the 'CHP+ Evidence of Coverage', also known as the Member Handbook:<br>- **V KPCO_CHP_PC_10062022**<br>- **V CHP+ Desktop Procedures_2023.09.21,** page 2<br><br>Also, each month KP mails new enrollees a 'CHP+ New Member Postcard'. This postcard informs members about important member documents and that information is online or can be printed by calling Member Services:<br>- **Chp+New-Member-Postca_COM_ CO-DB_2023_PC_EngSp-r2a-ja_COEdits** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change.<br>*42 CFR 438.10(g)(4)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.2.7.5 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Notice about changes to this Member Handbook, page 86 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider by the later of 30 calendar days prior to the effective date of the termination, or within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.<br>*42 CFR 438.10(f)(1)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.9.1 | **V H0630_22042_C CPMG PCP retire and term letter template** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 12. The Contractor shall develop and maintain a customized and comprehensive website that includes:<br>• The CHP+ MCO's contact information.<br>• Member rights and responsibilities.<br>• Member handbook.<br>• Grievance and appeal procedures and rights.<br>• General functions of the CHP+ MCO.<br>• Provider directory.<br>• Access to care standards.<br>• Colorado Crisis Services information. | Important member documents and information are posted online at:<br>Charitable Health Government Programs \| Kaiser Permanente Colorado Options (KP CHP+ Home Page)<br>- General functions of the CHP+ MCO.<br>https://charitablehealth.kaiserpermanente.org/colorado/member-resources/ (KP CHP+ Resource Page)<br>- The CHP+ MCO's contact information.<br>- Member rights and responsibilities. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • A link to the Department's website for standardized information such as member rights and handbooks.<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.8 | - Member handbook.<br>- Grievance and appeal procedures and rights.<br>- Provider directory.<br>- Access to care standards.<br>- Colorado Crisis Services information. | |
| 13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable):<br>• The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new members.<br>• The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.<br>• Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br><br>*Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory.*<br>*Electronic provider directories must be updated no later than 30* | The CHP+ provider directory is posted online at: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/<br><br>**chp-provider-directory-august-2023-co-en**<br>- Help in your language, page 2<br>- Serving Members with Diverse Backgrounds, page 3<br>- Physical Disability Accommodations, page 3<br>- Nondiscrimination notice, page 4<br>- Providers, page 14-165<br>  ○ Providers are listed by specialty.<br>  ○ KP reports languages other than English.<br><br>Note: The online KP.org directory information is updated monthly and the KP CHP+ Provider Directory PDF is updated quarterly. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *calendar days after the Contractor receives updated provider information.*<br>*42 CFR 438.10(h)(1-3)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.7-8 | | |
| **Findings:**<br>The provider directory on the website included the ability to search, download, and print. The provider directory allows members to use filters to search for providers with accommodations for people with physical disabilities. During the interview, however, staff members could not convey how the provider information was gathered to ensure its accuracy. | | |
| **Required Actions:**<br>Kaiser must develop a process to conduct outreach or other forms of communication with the provider to ensure the information on the website's provider directory is up to date and accurate. | | |
| 14. Provider directories are made available on the Contractor's website in a machine readable file and format.<br>*42 CFR 438.10(h)(4)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.9 | **chp-provider-directory-august-2023-co-en**<br><br>**Process for JSON with CHP Files 10.10.23**<br><br>Here is where the CHP+ Machine Readable files are posted, under 'Colorado':<br>Technical Information (kaiserpermanente.org) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 15. The member handbook provided to members following enrollment includes:<br>• The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. | **CHP_EOC_updates for 7.1.2023_Final**<br>- Benefits and services, Exclusions, and Limitations, page 36-83<br>  ○ KP CHP+ Health Plan Benefits Summary, page 37-45<br>- How to Get Care, page 18-35<br>  ○ Referrals, page 32 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.<br>• The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider.<br>• The process of selecting and changing the member's primary care provider.<br>• Any restrictions on the member's freedom of choice among network providers.<br>• In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services.<br><br>*42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5-7, 7.2.7.2.1.9-10, and 10.3.2 | ○ Pre-Approval/Authorizations, page 33<br>○ Family planning services, page 23<br>○ Out of Network, page 26<br>○ Primary Care Provider, page 29-30<br>○ CHP+ Provider Network, page 25<br>○ Moral Objection, page 24 | |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 16. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to:<br>• Receive information in accordance with information requirements (42 CFR 438.10).<br>• Be treated with respect and with due consideration for his or her dignity and privacy.<br>• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.<br>• Participate in decisions regarding his or her health care, including the right to refuse treatment.<br>• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.<br>• Request and receive a copy of his or her medical records, and request that they be amended or corrected.<br>• Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services.<br>• Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member.<br>*42 CFR 438.10(g)(2)(ix)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.6.3 and 7.3.7.2.1.16. | **CHP_EOC_updates for 7.1.2023_Final**<br>- Rights and Responsibilities, page 84 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 17. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames:<br>• The right to file grievances and appeals.<br>• The requirements and time frames for filing a grievance or appeal.<br>• The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member.<br>• The availability of assistance in the filing process.<br>*42 CFR 438.10(g)(2)(xi)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.23 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Reporting and solving problems, page 87-92<br>o Complaints, page 87<br>o Appeals, page 88<br>o State Review, page 90 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 18. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including:<br>• What constitutes an emergency medical condition and emergency services.<br>• The fact that prior authorization is not required for emergency services.<br>• The fact that the member has the right to use any hospital or other setting for emergency care.<br>*42 CFR 438.10(g)(2)(v)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.8.1-2, 7.3.7.2.1.8.4, and 7.3.7.2.1.8.7 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Urgent Care, page 20<br>- Emergency care, page 20-21 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 19. The member handbook provided to members following enrollment includes:<br>• Cost-sharing, if any is imposed under the State plan.<br>• How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract.<br>• How transportation is provided.<br>• The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.<br>• Information on how to report suspected fraud or abuse.<br>• How to access auxiliary aids and services, including information in alternative formats or languages.<br><br>*42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2, 7.3.7.2.1.2, 7.3.7.2.1.19.1, and 7.3.7.2.1.21 | **CHP_EOC_updates for 7.1.2023_Final**<br>- KP CHP+ Health Plan Benefits Summary, page 37-45<br>- Ambulance Services, page 49<br>- Important phone numbers, page 98<br>- Fraud, waste, and abuse, page 91<br>- Other languages and formats, page 5-6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 20. The Contractor provides member information by either:<br>• Mailing a printed copy of the information to the member's mailing address.<br>• Providing the information by email after obtaining the member's agreement to receive the information by email.<br>• Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with | Newly enrolled CHP+ members receive the below postcard about how to access the 'CHP+ Evidence of Coverage', also known as the Member Handbook:<br>- **V KPCO_CHP_PC_10062022**<br>- **V CHP+ Desktop Procedures_2023.09.21,** page 2<br><br>Also, each month KP mails new enrollees a 'CHP+ New Member Postcard'. This postcard | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard V—Member Information Requirements | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.<br>• Providing the information by any other method that can reasonably be expected to result in the member receiving that information.<br>*42 CFR 438.10(g)(3)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.12 | informs members about important member documents and that information is online or can be printed by calling Member Services:<br>- **Chp+New-Member-Postca_COM_ CO-DB_2023_PC_EngSp-r2a-ja_COEdits**<br><br>Important member documents and information are posted online at: https://charitablehealth.kaiserpermanente.org/colorado/member-resources/<br>- This website should also appear by searching for "KP Colorado CHP".<br>- All KP CHP member documents are posted on the 'Resources' page.<br>- Documents online can be saved or printed. | |
| 21. The Contractor must make available to members, upon request, any physician incentive plans in place.<br>*42 CFR 438.10(f)(3)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—7.3.5.1.13 | **CHP_EOC_updates for 7.1.2023_Final**<br>- Contracts with Network Providers, page 94 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard V—Member Information Requirements | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 18 | X | 1.00 | = | 18 |
| | Partially Met | = | 3 | X | .00 | = | 3 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 21 | **Total Score** | | = | 18 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 86% |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor implements written policies and procedures for selection and retention of providers.<br>*42 CFR 438.214(a)*<br>CHP+ Contract Amendment 2: Exhibit B2—9.1.7 and 9.1.10 | - **CPMG Physician Selection Process**<br>- **Provider Recruitment Retention Program_2023**<br>- **KFHP Credentialing Policy** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA).<br>The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration.<br>*42 CFR 438.214(b)*<br>CHP+ Contract Amendment 2: Exhibit B2—9.2.3 and 9.2.3.3 | **KFHP Credentialing Policy**, section 6.1<br>**CAP and CLIA ACCREDITATION**, section 1<br>**Credentialing of Healthcare Delivery Organizations Policy**, section 6.1<br><br>Kaiser Foundation Health Plan is NCQA accredited. These policies demonstrate our methods of credentialing and recredentialing participating providers and comply with NCQA guidelines. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not:<br>• Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. | **HR.009 Equal Opportunity and Anti-Harassment Policy of CPMG**<br><br>**Annual_Non_Discrimination_Report_2022**<br><br>**LEGAL_DOCS-#1730902-v4-PK__CO_-_Combined_KFH_(hospital)_and_KFHP_(profes** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.<br><br>*42 CFR 438.12(a)(1) and (2)*<br>*42 CFR 438.214(c)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—9.1.8-9 | **sional)_Template**, section 7.1.3 Nondiscrimination, page 24-25 | |
| 4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.<br>This is not construed to:<br>• Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members.<br>• Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.<br>• Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.<br><br>*42 CFR 438.12(a-b)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—9.1.11 | **Interested Provider Process Guide_10.05.2023**, step #6 page 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 5. The Contractor has a signed contract or participation agreement with each provider.<br><br>*42 CFR 438.206(b)(1)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—9.5.1.1 | **LEGAL_DOCS-#1730902-v4-PK__CO_-_Combined_KFH_(hospital)_and_KFHP_(professional)_Template**<br><br>**KFHP Credentialing Policy**, section 5.11.3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.<br>• The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals.<br><br>*(This requirement also requires a policy.)*<br><br>*42 CFR 438.214(d)*<br>*42 CFR 438.610*<br><br>CHP+ Contract Amendment 2: Exhibit B2—9.1.20 | **VII Identifying and Responding to Ineligible Individuals and Entities 2023**, section 1.0<br><br>**CHP+MonthlyFWARpt_8-2023** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.<br><br>*42 CFR 438.610*<br><br>CHP+ Contract Amendment 2: Exhibit B2—15.9.4.2 | **VII Identifying and Responding to Ineligible Individuals and Entities 2023**, section 1.0<br><br>**OwnshpCntrlDis_FY 23-24**<br><br>**VII Principles of Responsibility (8358_1)**, section 8 page 36 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following:<br>• The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.<br>• Any information the member needs in order to decide among all relevant treatment options.<br>• The risks, benefits, and consequences of treatment or non-treatment.<br>• The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.<br>*42 CFR 438.102(a)(1)*<br>CHP+ Contract Amendment 2: Exhibit B2—11.11.10 | **LEGAL_DOCS-#1730902-v4-PK__CO_-_Combined_KFH_(hospital)_and_KFHP_(professional)_Template**, section 2.9.1 page 14<br><br>**kpco-provider-manual-section-7-member-rights-en**, CHP+ Member Rights section 7.1 page 6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover:<br>• To the State upon contracting or when adopting the policy during the term of the contract.<br>• To members before and during enrollment.<br>• To members within 90 days after adopting the policy with respect to any particular service.<br>*42 CFR 438.102(a)(2)-(b)*<br>CHP+ Contract Amendment 2: Exhibit B2—11.7 | **CHP EOC 2023-2024 Final_ADA**, Moral objection page 24<br><br>**kpco_provider_manual-section-9-compliance-en**, Moral Objection statement page 4<br><br>Note: KP does not have any benefit restrictions due to moral or religious grounds | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable |
| 10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes:<br>• Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements.<br>• The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors.<br>• The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. | **VII Fraud, Waste, and Abuse Control 2021**<br>**VII Internal Reporting of Ethics and Compliance Concerns 2023**<br>**VII SOP for Investigations**<br><br>**VII Ethics and Compliance Program Description (9367_0)** This document provides information on Kaiser Permanente Health Plan of Colorado's compliance program, the structure of the compliance organization, information related to auditing and monitoring processes, prevention of fraud waste and abuse, and reporting structures.<br><br>**VII Condition of Employment and Required Training Natl HR 012**<br>**VII Conditoin of Employment and Required Training - Admnstration Standards Natl HR 012** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract.<br>• Effective lines of communication between the compliance officer and the Contractor's employees.<br>• Enforcement of standards through well-publicized disciplinary guidelines.<br>• Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks.<br>• Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract.<br>*42 CFR 438.608(a)(1)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.1.1 and 15.1.5.1-7 | **VII Conditoin of Employment and Required Training - Training Standards natl HR 012**<br>Compliance Training is done upon employment and annually for Kaiser Permanente. The content in the attached training was used for both new hires and annual refresher training. The Compliance training is online for Kaiser Permanente Employees on KP Learn. This training requires attestation on the Principals of Responsibility and Annual Compliance Training which addresses how to report compliance concerns.<br><br>**VII Principles of Responsibility (8358_1)**,<br>- 1.3 Where to Go for More Help page 8<br>- Section 10 Know How To Get Help p50-52 | |
| 11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include:<br>• Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. | **VII Fraud, Waste, and Abuse Control 2021**<br>**VII Internal Reporting of Ethics and Compliance Concerns 2023**<br>**VII SOP for Investigations**<br><br>**VII Ethics and Compliance Program Description (9367_0)** This document provides information on Kaiser Permanente Health Plan | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit.<br>• Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23.)<br><br>*42 CFR 438.608 (a)(6-8)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—1.14.1, 15.1.5.9, 15.1.6, and 15.7.1<br><br>10 CCR 2505-10, Section 8.076 | of Colorado's compliance program, the structure of the compliance organization, information related to auditing and monitoring processes, prevention of fraud waste and abuse, and reporting structures.<br><br>**VII Condition of Employment and Required Training Natl HR 012**<br>**VII Conditoin of Employment and Required Training - Admnstration Standards Natl HR 012**<br>**VII Conditoin of Employment and Required Training - Training Standards natl HR 012**<br>Compliance Training is done upon employment and annually for Kaiser Permanente. The content in the attached training was used for both new hires and annual refresher training. The Compliance training is online for Kaiser Permanente Employees on KP Learn. This training requires attestation on the Principals of Responsibility and Annual Compliance Training which addresses how to report compliance concerns.<br><br>**VII Principles of Responsibility (8358_1)**,<br>- 1.3 Where to Go for More Help page 8<br>- Section 10 Know How To Get Help p50-52<br><br>**LEGAL_DOCS-#1730902-v4-PK__CO_-_Combined_KFH_(hospital)_and_KFHP_(professional)_Template**, Compliance page 44-45 | |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 12. The Contractor's Compliance Program includes:<br>• Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud.<br>• Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death.<br>• Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.<br>• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.<br>*42 CFR 438.608 (a)(2-5)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.1.5.7.6, 15.3.1.1, and 15.3.1.3.2.1 | **Suggested Document:**<br>Most recent Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report<br><br>**Submitted Documents:**<br><br>CHP+ FWARpt_Q3-Q4 FY 22-23_8.11.2023<br>CHP+MonthlyFWARpt_8-2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State.<br>• The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected members.<br>*42 CFR 438.608 (b)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.9.2 | **kpco_provider_manual-section-9-compliance-en**, Section 9.1.1 Medicaid and CHP+ Providers page 4<br>**Process for Monthly MCO Audit 10.10.23** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 14. The Contractor has procedures to provide to the State:<br>• Written disclosure of any prohibited affiliation (as defined in 438.610).<br>• Written disclosure of ownership and control (as defined in 455.104)<br>• Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract.<br>*42 CFR 438.608(c)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.9.4.3, 15.10.4.2, and 15.3.1.5.1.1 | **VII ARP Policy**, section 1 and 2 page 1<br>**VII August 2023 CHP+ ARP Output v2**<br>**VII Internal Reporting of Overpayments, Self-Disclosure, and repayment for federal health program and ACA funds 2023**, section 1 and 2 page 1<br>**OwnshpCntrlDis_FY 23-24** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Provider Selection and Program Integrity | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment.<br>• The Contractor reports annually to the State on recoveries of overpayments.<br>*42 CFR 438.608(d)(2) and (3)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.1.5.8 | **kpco-provider-manual-section-5-billing-and-payment**, Section 5.3.5 Claims adjustment page 18-19<br><br>**21-22 CO CHIP Questionnaire_Template**, row 21 Overpayment recoveries received from network providers | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 16. The Contractor provides that members are not held liable for:<br>• The Contractor's debts in the event of the Contractor's insolvency.<br>• Covered services provided to the member for which the State does not pay the Contractor.<br>• Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement.<br>• Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.<br>*42 CFR 438.106*<br>CHP+ Contract Amendment 2: Exhibit B2—15.12.2-4 | **LEGAL_DOCS-#1730902-v4-PK__CO_-_Combined_KFH_(hospital)_and_KFHP_(professional)_Template**, Member Hold Harmless page 16<br><br>**CHP EOC 2023-2024 Final_ADA**, Contracts with Network Providers page 94 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard VII—Provider Selection and Program Integrity | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 15 | X | 1.00 | = | 15 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 1 | X | NA | = | NA |
| **Total Applicable** | | = | 15 | **Total Score** | | = | 15 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 100% |

| Standard IX—Subcontractual Relationships and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.<br><br>*42 CFR 438.230(b)(1)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4 | **IX Delegation Oversight 2021**, Section 6.1, 6.5 page 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. All contracts or written arrangements between the Contractor and any subcontractor specify—<br>• The delegated activities or obligations and related reporting responsibilities.<br>• That the subcontractor agrees to perform the delegated activities and reporting responsibilities.<br>• Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily.<br><br>*Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.*<br><br>*42 CFR 438.230(b)(2) and (c)(1)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4 | **IX Delegation Oversight 2021**, Section 6.1, 6.5 page 2<br><br>**1 Delegated Credentialing Services_Agreement Template 12-2022**<br>- Section B., Section C, page 2-3<br>- Section III. A.6. page 5 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontractual Relationships and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 3. The Contractor's written agreement with any subcontractor includes:<br>• The subcontractor's agreement to comply with all applicable CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions.<br>*42 CFR 438.230(c)(2)*<br>CHP+ Contract Amendment 2: Exhibit B2—2.5.4.6 | **1 Delegated Credentialing Services_Agreement Template 12-2022**<br>- Section II.C.1, page 3<br>- Section VI. A and B, page 6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 4. The written agreement with the subcontractor includes:<br>• The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.<br>– The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.<br>– The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.<br>– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS | MedImpact:<br>- IX PBM 18. SERVICE AGREEMENT Amendment (CO Regulatory-Audit Reqs) - Effective 2022-05.17, section 10.18 page 1<br><br>Memorial:<br>- Memorial Hospital - 2016-2-8 Agreement for Delegated Credentialing Services<br><br>UPI:<br>- University Physicians Inc - 2015-9-24 Agreement for Delegated Credentialing Services<br>- 2021_07_01 UPI-CU Medicine Credendialing Amd, section J page 1 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontractual Relationships and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| Inspector General may inspect, evaluate, and audit the subcontractor at any time.<br>*42 CFR 438.230(c)(3)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.10.11 | | |
| **Findings:**<br>Kaiser included all requirements in the contract template and most of the delegated agreements that it submitted as evidence. The agreement with UPI did not include the required language regarding the right of the State, CMS, or the HHS Inspector General to inspect, evaluate, and audit the subcontractor at any time if there is a reasonable probability of fraud or similar risk. | | |
| **Required Actions:**<br>Kaiser must update the agreement between Kaiser and UPI to include the required language. To show evidence of completion, Kaiser must show an approved amendment. | | |

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

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.<br>*42 CFR 438.330(a)(1)*<br>CHP+ Contract Amendment 2: Exhibit B-2—14.1.1 | Quality assessment and improvement tis the key function of the KP's Quality Program. The document below describes KP's quality program.<br>• KPCO_2023 Quality Program Description<br>  ○ Page 4 Mission and Vision<br>  ○ Page 6 KPCO Quality Oversight Committee<br>  ○ Page 7 Annual Work Plan and Evaluation | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following:<br>• Measurement of performance using objective quality indicators.<br>• Implementation of interventions to achieve improvement in the access to and quality of care.<br>• Evaluation of the effectiveness of the interventions based on the objective quality indicators.<br>• Planning and initiation of activities for increasing or sustaining improvement.<br>*42 CFR 438.330(b)(1) and (d)(2) and (3)*<br>CHP+ Contract Amendment 2: Exhibit B-2—14.2.1.1, 14.3 | Quality assessment and improvement is the key function of the KP's Quality Program. The documents below describe KP's quality workplan and evaluation.<br>• KPCO_2023 Quality Program Workplan, Regulatory Oversight CHP Goal, Page 12 (B2, B4)<br>• KPCO_2022 Quality Program Evaluation, Page 18-19 (B3)<br>The document below describes KP's CHP+ PIP:<br>• CO2023-24 PIP Submission Form_F1_Well Child PIP<br>• CO2023-24 PIP Submission Form_F1_SDOH PIP<br>• SDOH Dashboard 10.3.2023<br>• HEDIS Rate Trend Dashboard Screenshot 10.3.2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually:<br>• Performance measure data using standard measures identified by the State.<br>• Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State.<br>• A combination of the above activities.<br>*42 CFR 438.330(b)(2) and (c)*<br>CHP+ Contract Amendment 2: Exhibit B2—14.4 | KP's Quality Program includes reporting and improving Performance Measures:<br>• KPCO_2023 Quality Program Description, Page 7 Clinical Quality Oversight Program<br>• KPCO_2023 Quality Program Workplan, Page 12<br>• CO_Child Core Set_RRT_MY2022_FINAL UPDATED TEMPLATE 7.6.2023, annual CMS Core Measure report | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services.<br>*42 CFR 438.330(b)(3)*<br>CHP+ Contract Amendment 2: Exhibit B-2—14.6 | Mechanisms to detect over- and underutilization of services are in place and incorporated into KP's Quality Program and analyzed. These mechanisms include reports which shows over- and under-utilization. The Medicaid and CHP Quality Governance subcommittee evaluates utilization statistics and determines actions needed for identified problems.<br>• KPCO_2023 Quality Program Description, Page 17 Utilization Management<br>• KPCO_MCP Quality Charter 2023<br>• 20231010AgendaMinutes Quality, page 9, 12-13<br>• 20230822 MCP Well Visit Workgroup Agenda and Minutes<br>• X PED ASTHMA ED FOLLOW UP_V2_ | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • SDOH Dashboard 10.3.2023<br>• HEDIS Rate Trend Dashboard Screenshot 10.3.2023<br>• X 15.1.GPOC_Report_HighRiskPeds Strategy_September_2023v2 | |
| 5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.<br><br>*Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.*<br><br>*42 CFR 438.330(b)(4)*<br><br>CHP+ Contract Amendment 2: Exhibit B2—14.6.1 | The Complex Case Management program has been developed based on NCQA standards and includes an initial assessment, criteria for follow-up, goals of care and monitoring through both a reporting workbench and a high-risk reporting workbench/panel reports. In addition, quarterly chart audit is in place within the QAPI program to assess the quality and appropriateness of care rendered to members with special healthcare needs:<br>• KPCO_2023 Quality Program Description, Page 15 Population Health Management and Integrated Care<br>• Pediatric Care Coordination Program Description 2023, Page 4 Managing Members with SHCN and Complex Patients<br>• PCM Playbook 2023, page 4, 6<br>• X DCM Program Manual Revised 2021<br>• X CCOC_2023_ContinuumofCareOversight Committee_Charter_2023 Update 1.11.23 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • X CCOC_Agenda_August_8_2023 AgendaMinutes<br>• X 15.1.GPOC_Report_HighRiskPeds Strategy_September_2023v2 | |
| 6. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including:<br>• Member surveys.<br>• Anecdotal information.<br>• Grievance and appeals data.<br>• Call center data.<br>• Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys.<br><br>CHP+ Contract Amendment 2: Exhibit B-2—14.5.2-3 | KP provides monthly and quarterly reporting to the CHP+ Contract Manager at Health Care Policy and Financing which includes call center performance and appeals and grievance data. This data is monitored internally by KP prior to submission to the state.<br>• KPCO_MCP Quality Charter 2023<br>• 20231010AgendaMinutes Quality<br>• GrieveAppealRpt_Q2 2023_SFY Q4 2023_8.11.2023<br>• CHP+ GrieveAppealRpt_Q2 2023_SFY Q4 2023_8.11.2023<br>• CO_CHP Health Plan Operations Scorecard Spec Sheet Claims_8.11.2023<br>• Health Plan Operations Scorecard Spec Sheet without claims – Kaiser<br>• X GPOC Report_MCD_CHP_Oct 2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

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

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually.<br><br>*42 CFR 438.330(e)(2)*<br><br>CHP+ Contract Amendment 2: Exhibit B-2—14.2.5 | KP submits the annual Quality Improvement Workplan to the Health Care Policy & Financing CHP+ Contract Manager annually<br>• KPCO_2023 Quality Program Description<br>  ○ Page 7 Annual Work Plan and Evaluation<br>• KPCO_2022 Quality Program Evaluation<br>  ○ Page 18-19 Quality Goals for CHP+ and Medicaid | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 8. The Contractor adopts or develops practice guidelines that meet the following requirements:<br>• Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.<br>• Consider the needs of the Contractor's members.<br>• Are adopted in consultation with participating providers.<br>• Are reviewed and updated periodically, as appropriate.<br><br>*42 CFR 438.236(b)*<br><br>CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.2-4 | These documents outline how guidelines are developed:<br>• X Clinical Guideline Policy and Procedure - 2023<br>  ○ 4.1.2, page 2-3 (B1)<br>  ○ 2.0, page 1 (B2)<br>  ○ 4.1.1, page 2 (B3)<br>  ○ 4.2.1, page 3 (B4)<br>• X UM Clinical Criteria for UM Decisions 7.23, page 1-3 sections 2.0, **5.1, 5.2** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 9. The Contractor adopts or develops practice guidelines for the following:<br>• Perinatal, prenatal, and postpartum care.<br>• Conditions related to persons with a disability or special health care needs.<br>• Well-child care.<br><br>CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.1 | Included below are examples of clinical guidelines:<br>• Maternity Care — member guide to maternity care.(B1)<br>• Pregnancy Toolkit — member guide to being pregnant. (B1)<br>• Labor and Delivery Toolkit — member labor and delivery guide. (B1)<br>• Postpartum Toolkit — member guide for the 6 weeks after delivery. (B1)<br>• Women's Health Classes — member support from staff trained in breastfeeding baby. (B1)<br>• Perinatology Clinical Reference 2023 (B1)<br>• X Clinical Guideline DX AND MANAGEMENT OF ADHD IN CHILDREN AND ADOLESCENTS (B2)<br>• X Clinical Guideline DEVELOPMENTAL DELAY AND AUTISM REFERRAL PATHWAYS (B2)<br>• X Clinical Guideline DEPRESSION GUIDELINE FOR ADOLESCENS AGED 12 THROUGH 17 (B2)<br>• X Clinical Guideline AAP BRIGHT FUTURES RECS FOR PREVENTIVE PEDS HEALTH CARE (B3)<br>• Prenatal-Preventive-Services-Clinical-Practice-Guideline (B3) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • X Clinical Guideline DIRECTORY OF WOMEN AND CHILDRENS HEALTH INFO (B3) | |
| 10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, and potential members.<br>*42 CFR 438.236(c)*<br>CHP+ Contract Amendment 2: Exhibit B-2—10.5.8 | The following document describes how the guidelines are disseminated.<br>• KPCO_2023 Quality Program Description, Page 17 Utilization Management<br>• kpco-provider-manual-section-4-utilization-management-en, page 5 section 4.2<br>• CHP EOC 2023-2024 Final_ADA, Page 35 Utilization Management section<br>• X Clinical Library Policy and Procedure – 2023<br>• All Care Gap Definitions and Tips - 2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.<br>*42 CFR 438.236(d)*<br>CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.5 | The following document describes how utilization management guidelines are consistent with the guidelines.<br>• KPCO_2023 Quality Program Description, Page 17 Utilization Management<br>• X UM Authorization of Service Policy 04.27.2023, page 1 section 5.0<br>• X UM Clinical Criteria for UM Decisions 7.23<br>• X Clinical Guideline Policy and Procedure - 2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • X Clinical Library Policy and Procedure - 2023 | |
| 12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.<br><br>*42 CFR 438.242(a)*<br><br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.1 and 15.10.2 | KP maintains a health information system that collects, analyzes, integrates and reports data.<br>• KPCO_2023 Quality Program Description<br>  ○ Page 6 KPCO Quality Oversight Committee<br>  ○ Page 6 QOC Subcommittee Functions<br>  ○ Page 7 Annual Work Plan and Evaluation<br>• Att_6.1_Data Integration Flowchart_KPCO_2022 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility.<br><br>*42 CFR 438.242(a)*<br><br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.1 and 8.1 | KP uses clinical information, membership demographics, and communications with members to integrate data for care management and reporting needs.<br>• KPCO_2023 Quality Program Description<br>  ○ Page 12 Care Experience<br>  ○ Page 13 Care Experience Assessment<br>• GrieveAppealRpt_Q2 2023_SFY Q4 2023_8.11.2023<br>• CHP+ GrieveAppealRpt_Q2 2023_SFY Q4 2023_8.11.2023<br>• CO_CHP Health Plan Operations Scorecard Spec Sheet Claims_8.11.2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • Health Plan Operations Scorecard Spec Sheet without claims – Kaiser<br>• CHP Monthly Enrollment Reports [PHI] | |
| 14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State.<br>• Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process.<br>*42 CFR 438.242(b)(1)*<br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.3 | The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado.<br>• Medicaid Encounter Data Submission Process Flow CO 2022 04.04 Final Approved<br>• CO_Response_Report_September2023_10032023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State).<br>*42 CFR 438.242(b)(2)*<br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.5.1 and 13.1.6.2 | Medicaid Encounter Data Submission Process Flow CO 2022 04.04 Final Approved<br><br>Colorado Metrics Meeting_Aug | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 16. The Contractor ensures that data received from providers are accurate and complete by:<br>• Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments.<br>• Screening the data for completeness, logic, and consistency.<br>• Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts.<br>*42 CFR 438.242(b)(3) and (4)*<br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.7.1.2.1 and 13.1.6 | The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado.<br>• Medicaid Encounter Data Submission Process Flow CO 2022 04.04 Final Approved<br>• CO_Response_Report_September2023_10032023<br>• Encounter_Data_Monthly_Certification_9.29.2023<br><br>Att_6.1_Data Integration lowchart_KPCO_2022 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 17. The Contractor:<br>• Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members.<br>• Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate.<br>• Submits member encounter data to the State at the level of detail and frequency specified by the State.<br>*42 CFR 438.242(c)*<br>CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.2-3 and 13.1.6.4-5 | The attached process document outlines the process and systems used by Kaiser Permanente of Colorado to submit encounter claims to the State of Colorado.<br>• Medicaid Encounter Data Submission Process Flow CO 2022 04.04 Final Approved<br>• CO_Response_Report_September2023_10032023<br>• Encounter_Data_Monthly_Certification_9.29.2023 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 17 | X | 1.00 | = | 17 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 17 | **Total Score** | | = | 17 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 100% |

# Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of **Kaiser**.

**Table B-1—HSAG Reviewers and Kaiser and Department Participants**

| HSAG Review Team | Title |
|---|---|
| Gina Stepuncik | Associate Director |
| Crystal Brown | Project Manager I |
| Cynthia Moreno | Project Manager III |
| **Kaiser Participants** | **Title** |
| Alissa Mickartz | Senior Human Resources Business Partner, Medical Office Administration—Subspecialty |
| Amy Archer | Medical Audit Coordinator, Registered Nurse, Utilization Review Case Management—Specialty |
| Amy Bodette | Regional Director I, Population Management—Disease Management |
| Dr. Andrew Maclennan | Medical Director, Prevention, Internal Medicine |
| Beth Champlin | Director, Regional Credentialing, Regional—Other Administration |
| Carlos Madrid | Senior Manager, Health Commercial Management, Health Plan Manager—Medicare/Medicaid |
| Casey Snow | Accreditation Specialist, Legal |
| Cheryl Read | Quality Oversight Program Specialist, Legal |
| Chris Laidley | Senior Manager, Process Improvement, Medicaid Charitable Coverage |
| Cindy Freeman | Credential Program/Compliance Coordinator, Regional—Other Administration |
| Connie Akers | Quality Review Coordinator, Legal |
| Daisy Strickland | Consultant V, Member Services, Shared Service |
| Elizabeth Bradley | Project Manager III, Group Relations—Health Care Procedure Administration |
| Elizabeth Chapman | Medicaid Contract Compliance Manager, Health Plan Manager—Medicare/Medicaid |
| Emily Furseth | Marketing Consultant IV, Group Relations—Marketing Communications |
| Erica Anderson | Senior Director of Operations, Medical Office Administration—Team Operations |
| Erika Sandoval | Compliance Consultant IV, Member Services, Shared Service |
| Gerardo Espinoza | Clinical Consultant III, Medical Foundation |
| Heidi Lorenz | Senior Director, Population Health Operations, Medical Foundation |

| Kaiser Participants | Title |
|---|---|
| Irene Nora | Senior Director, Compliance, Member Services, Shared Service |
| Jamal West | Senior Manager, Recruiting Operations, Medical Foundation |
| Janine M. Vincent | Compliance Consultant VI, National Claims Service Organization |
| Jennifer J. Rayford | Manager, Human Resources, Talent Acquisition, Regional Operations |
| Kathleen Westcoat | Senior Director, Medicaid, Health Plan Manager—Medicare/Medicaid |
| Khalilah Hunter | Consultant, Provider Experience, Group Relations—Health Care Procedure Administration |
| Kirsten Swart | Compliance Consultant IV, Regional Compliance |
| Dr. Lauren Galpin | Medical Director, Medicaid and Charitable Programs, Internal Medicine |
| Leah Reed | Chief Pharmacist, Pharmacy Administration—Pharmacy Benefit Management |
| Dr. Lise Barbour | Director, Physician Retention and Wellness, Internal Medicine—Palliative Care |
| Mark Stotik | Director, Human Resources, Regional Human Resources, Specialty Services |
| Marty Schultz | Director, Network Operations, Group Relations—Health Care Procedure Administration |
| Maryann Blume | Manager, Compliance, Compliance Investigations |
| Mesha Sanford | Process Improvement Consultant V, Technical Services |
| Michele O'Neal | Consultant II, Medicaid Charitable Coverage |
| Mikala Gibbs | Project Manager V, Group Relations—Health Care Procedure Administration |
| Nikki Bridgeforth | Program Manager IV, National Benefit Operations |
| Rachel Cobb | Lab/Quality Assurance/Compliance Manager, Regional, Other Laboratory Administration |
| Renae Pemberton | Senior Director, Provider Contracting, Group Relations—Health Care Procedure Administration |
| Rhonda Meili | Manager, Network Provider Relations, Group Relations—Health Care Procedure Administration |
| Rhonda Rutherford | Compliance Consultant IV, Member Services, Shared Service |
| Robert Beltran | Data Analyst IV, Medical Office Support |
| Robin Beagle | Director, Accreditation, Regulatory and Licensure, Legal |
| Robin Dam | Compliance Consultant V, Regional Compliance |
| Sakeen Sarem Aslani | Senior Human Resources Business Partner, Medical Office Administration—Subspecialty |
| Stephanie Gelsey | Marketing Consultant V, Group Relations—Marketing Communications |

| Kaiser Participants | Title |
|---|---|
| Stephanie Skarulis | Accreditation Specialist, Legal |
| Tamara N. Neiman | Executive Director, National Special Investigations Unit, Compliance Investigations |
| Tammy Sheldon | Data Reporting and Analytics Consultant III, Compliance and Regulatory Group Relations—Health Care Procedure Administration |
| Tanya Carbone | Senior Human Resources Manager, Medical Office Administration—Subspeciality |
| Tina Santos | Compliance Consultant IV, Group Relations—Sales & Marketing Integration |
| Tracy Copeland | Project Manager IV, Health Plan Manager—Medicare/Medicaid |
| Tracy L. Marton | Senior Recruiter, Regional Manager, Recruiting |
| Vanessa McDonald | Compliance Consultant III, Compliance Health Plan |
| **Department Observers** | **Title** |
| Russell Kennedy | Quality and Compliance Specialist |
| Hilary Erickson | Quality and Program Integrity Specialist |
| Valerie Joyner | Compliance Specialist |

# Appendix C. Corrective Action Plan Template for FY 2023–2024

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

**Table C-1—Corrective Action Plan Process**

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

| Step | Action |
|---|---|
| **Step 5** | **Technical assistance** |
| At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document. | |
| **Step 6** | **Review and completion** |
| Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements.<br>Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for resubmission established by the Department.<br>HSAG will continue to work with the MCE until all required actions are satisfactorily completed. | |

The CAP template follows on the next page.

**Table C-2—FY 2023–2024 Corrective Action Plan for Kaiser**

| Standard V—Member Information Requirements |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost.<br>• Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.<br>• All written materials for members must:<br>– Use easily understood language and format.<br>– Use a font size no smaller than 12 point.<br>– Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency.<br>– Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.<br>*42 CFR 438.10(d)(2-3) and (d)(6)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7 |
| **Findings** |
| Kaiser submitted several forms of written information that the member may obtain that included complete taglines. The taglines in the provider directory PDF and the new member postcard did not include how to request auxiliary aids and services. |
| **Required Actions** |
| Kaiser must revise the provider directory PDF and the new member postcard to describe how the member can request auxiliary aids and services. |

| Standard V—Member Information Requirements |
|---|
| **Planned Interventions** |
| |
| **Person(s)/Committee(s) Responsible** |
| |
| **Training Required** |
| |
| **Monitoring and Follow-Up Activities Planned** |
| |
| **Documents to Be Submitted as Evidence of Completion** |
| |
| **HSAG Initial Review:** |
| **Documents Included in Final Submission:** ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)*** |
| **Date of Final Evidence:** |

| Standard V—Member Information Requirements |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:<br>• The format is readily accessible (see definition of readily accessible above).<br>• The information is placed in a website location that is prominent and readily accessible.<br>• The information can be electronically retained and printed.<br>• The information complies with content and language requirements.<br>• The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days.<br>*42 CFR 438.10(c)(6)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.12.1.1-5 |
| **Findings** |
| Kaiser included a desktop procedure, literature report procedure, and "how to order literature" process as evidence. Each document used inconsistent language to describe the time frame required for sending the member requested information in paper form. |
| **Required Actions** |
| Kaiser must revise the desktop procedure, literature report procedure, and "how to order literature" process to be consistent with the time frame in the requirement. |
| **Planned Interventions** |
| |

| Standard V—Member Information Requirements |
|---|
| **Person(s)/Committee(s) Responsible** |
| |
| **Training Required** |
| |
| **Monitoring and Follow-Up Activities Planned** |
| |
| **Documents to Be Submitted as Evidence of Completion** |
| |
| **HSAG Initial Review:** |
| **Documents Included in Final Submission:** ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)*** |
| **Date of Final Evidence:** |

| Standard V—Member Information Requirements |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable):<br>• The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new members.<br>• The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.<br>• Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br><br>*Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory. Electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.*<br>*42 CFR 438.10(h)(1-3)*<br>CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.7-8 |
| **Findings** |
| The provider directory on the website included the ability to search, download, and print. The provider directory allows members to use filters to search for providers with accommodations for people with physical disabilities. During the interview, however, staff members could not convey how the provider information was gathered to ensure its accuracy. |
| **Required Actions** |
| Kaiser must develop a process to conduct outreach or other forms of communication with the provider to ensure the information on the website's provider directory is up to date and accurate. |
| **Planned Interventions** |
| |

| Standard V—Member Information Requirements |
|---|
| **Person(s)/Committee(s) Responsible** |
| |
| **Training Required** |
| |
| **Monitoring and Follow-Up Activities Planned** |
| |
| **Documents to Be Submitted as Evidence of Completion** |
| |
| **HSAG Initial Review:** |
| **Documents Included in Final Submission:** ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)*** |
| **Date of Final Evidence:** |

| Standard IX—Subcontractual Relationships and Delegation |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 4. The written agreement with the subcontractor includes:<br>• The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.<br>– The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.<br>– The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.<br>– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.<br>*42 CFR 438.230(c)(3)*<br>CHP+ Contract Amendment 2: Exhibit B2—15.10.11 |
| **Findings** |
| Kaiser included all requirements in the contract template and most of the delegated agreements that it submitted as evidence. The agreement with UPI did not include the required language regarding the right of the State, CMS, or the HHS Inspector General to inspect, evaluate, and audit the subcontractor at any time if there is a reasonable probability of fraud or similar risk. |
| **Required Actions** |
| Kaiser must update the agreement between Kaiser and UPI to include the required language. To show evidence of completion, Kaiser must show an approved amendment. |
| **Planned Interventions** |
| |

| Standard IX—Subcontractual Relationships and Delegation |
|---|
| **Person(s)/Committee(s) Responsible** |
| |
| **Training Required** |
| |
| **Monitoring and Follow-Up Activities Planned** |
| |
| **Documents to Be Submitted as Evidence of Completion** |
| |
| **HSAG Initial Review:** |
| **Documents Included in Final Submission:** ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)*** |
| **Date of Final Evidence:** |

# Appendix D. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

**Table D-1—Compliance Monitoring Review Activities Performed**

| For this step, | HSAG completed the following activities: |
|---|---|
| **Activity 1:** | **Establish Compliance Thresholds** |
| | Before the review to assess compliance with federal managed care regulations and Department contract requirements:<br>• HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.<br>• HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates.<br>• HSAG submitted all materials to the Department for review and approval.<br>• HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs. |
| **Activity 2:** | **Perform Preliminary Review** |
| | • HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed.<br>• HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review.<br>• Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested.<br>• Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.<br>• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review. |

| For this step, | HSAG completed the following activities: |
|---|---|
| **Activity 3:** | **Conduct the Review** |
| | • During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance.<br>• HSAG requested, collected, and reviewed additional documents as needed.<br>• At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings. |
| **Activity 4:** | **Compile and Analyze Findings** |
| | • HSAG used the FY 2023–2024 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities.<br>• HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies.<br>• HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings. |
| **Activity 5:** | **Report Results to the Department** |
| | • HSAG populated the Department-approved report template.<br>• HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment.<br>• HSAG incorporated the MCE and Department comments, as applicable, and finalized the report.<br>• HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations.<br>• HSAG distributed the final report to the MCE and the Department. |