MAC Binder Section 3C – Corrective Action Plans

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22 – HU2016PL-1 CAP Event_dte062315:

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MAC Binder Section 3C – Corrective Action Plans

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CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

January 8, 2016

Sabrina Moore and Terence Byrd
Director of Compliance
CoventryCares of Kentucky
9900 Corporate Campus, Suite 1000
Louisville, KY 40223

RE: CC2016UL-1

Dear Ms. Moore and Mr. Byrd:

We are writing this Letter of Concern regarding an issue between your subcontractor, MH/NET, and the University of Louisville (U of L).

U of L sent a letter to Commissioner Lisa D. Lee (attached) regarding non-payment of observation codes by MH/Net. MH/Net is incorrectly instructing U of L to use an inpatient *place of service* code (21) instead of the outpatient *place of service* code (22.) There is not a *place of service* code specifically for observation so 22-outpatient is used when billing. U of L is correct in stating the codes 99217-99219 are observation codes and therefore should not have a *place of service* of 21 (inpatient). The appropriate *place of service* code is 22 (outpatient).

Please note: If a patient is an inpatient, an order will be written by a physician making them an inpatient. A patient in observation status has not been formally admitted to the facility and therefore is not an inpatient. An observation status is not the same as an inpatient and therefore the place of service codes are not interchangeable.

In accordance with Contract Section 40.4(A), we are asking that Coventry notify us within two business days of receipt of this letter to review this specific information and let us know how Coventry will ensure that this error does not occur in the future.

We look forward to receiving Coventry's response and will be available for your questions throughout the process.

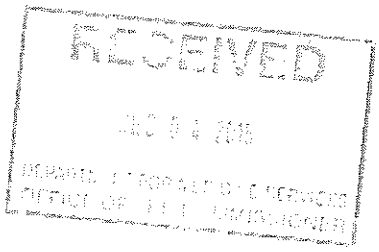
Sincerely,

David McAnally
Branch Manager

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Central Office Attorney, Office of Legal Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

UNIVERSITY OF
LOUISVILLE.

Office of HSC Financial Affairs



November 30, 2015

Lisa Lee, Commissioner
Department for Medicaid Services
Program Director, Kentucky Children's Health Insurance Program (KCHIP)
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

RE: MHNet Observation Services Billing

Dear Ms. Lee:

Thank you in advance for your assistance.

ULP/ULRF has worked with MHNet (mental health vendor for Coventry Cares of KY – KY Medicaid MCO) for well over a year and has exhausted all avenues to come to an agreement on how to bill and receive payment for observation services (CPT codes 99217, 99218, & 99219). Having exhausted all avenues with MHNet, we now come to you for assistance. We continue to see their patients so as not to put the patients in the middle of our billing disagreement yet our claims continue to mount and continue to be denied for the above mentioned services.

The issue is that we cannot agree with MHNet's direction on billing for observation services rendered to a patient who has *not* been admitted to the hospital. MHNet has directed us that "claims billed with 99217-99219 must be billed with a POS 21 [inpatient place of treatment] in order for MHNet to reimburse." (MHNet email, 7/15/14.) We feel we cannot use the inpatient place of treatment when a patient has not been admitted to the facility; thus, we have not been paid for an observation services rendered to a MHNet patient since December of 2013. Among the documentation we provided to MHNet to support our billing belief are the following:

- Without exception, every single other plan/payer (commercial, Medicaid and Medicare) reimburses for CPT codes 99217-99219 when billed as an outpatient place of service.
- CMS has ruled that "observation status refers to the classification of hospital patients as 'outpatients' ..." – as outlined in the article published by The Center for Medicare Advocacy discussing the ruling by CMS effective October 1, 2013. (article weblink - http://www.medicareadvocacy.org/observation-status-new-final-rules-from-cms-do-not-help-medicare-beneficiaries/)

University of Louisville • Abell Administration Center, Suite 312 • Louisville, KY 40202 P: 502.852.5189 F: 502.852.6849

CoventryCares™
of Kentucky
Lighting Your Path to Good Health

1/19/16

Via Certified Mail

David McAnally
Department for Medicaid Services
Cabinet for Health and Family Services
275 E. Main St. 6C-C
Frankfort, KY 40621

Re: LOC – CC2016UL-1

Dear David McAnally:

We have received your notice dated January 8, 2016 regarding the CPT codes 99217 – 99219 and POS 21 vs POS 22. We have reviewed internally and will be able to correct this issue for University of Louisville as you have indicated by allowing the codes with POS 22. We anticipate this will be completed on or before 2/1/16 and we will have our Provider Relations staff outreach to University of Louisville to update them accordingly.

CoventryCares of Kentucky is committed to meeting our obligations. We believe this letter answers your concerns. Should you have any questions or concerns, please feel free to contact me.

Best Regards,

Sabrina Moore
Plan Compliance Officer

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Vickie Yates Brown Glisson
Secretary

Veronica L. Judy-Cecil
Acting Commissioner

February 2, 2016

Sabrina Moore, Director of Compliance
Terence L. Byrd, Chief Executive Officer
Aetna Better Health of Kentucky
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016UL-1

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of Aetna's response developed for CC2016UL-1 (Letter of Concern regarding Section 4.3 Delegation of Authority) dated January 19, 2016.

Please be advised that the response is accepted upon the following conditions:

Aetna is required to provide all outcomes to DMS. DMS would like an update on this process within ten (10) business days of receipt of this notification (via certified mail). Please provide what procedures were put in place by Aetna to ensure that this problem is corrected with their subcontractor and will be resolved for future payment of service codes.

As you are aware this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Veronica L. Judy-Cecil, Acting Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

aetna®

9900 Corporate Campus Dr.
Suite 1000
Louisville, KY 40223

2/18/16

Via Certified Mail

DAVID MCANALLY
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH AND FAMILY SERVICES
275 E. MAIN ST. 6C-C
FRANKFORT, KY 40621

Re: Conditional Acceptance CC2016UL-1

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated February 2, 2015 with regard conditional acceptance of CC2016UL-1.

In response to the issue regarding 99217-99219 and Place of Service 21 & 22, Aetna Better Health of Kentucky has pulled a claims report for University of Louisville to identify the claims that need to be adjusted. We are currently in the process of confirming with the provider that the report encompasses the full universe of claims to be adjusted. We expect this to be completed by 2/24/16.

As the root cause of this error was due to the University of Louisville's original contract load, we are confident this will not occurred again as the contract has been updated and corrected. In the future all contracts that require changes are reviewed and approved by management. This will ensure all and any changes are captured in the future.

Aetna Better Health of Kentucky is committed to meeting our obligations. We believe this letter answers your concerns. Should you have any follow up questions or concerns, please feel free to contact me at (502) 719-8809.

Best Regards,

Sabrina Moore
Plan Compliance Officer

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2/18/16

Via Certified Mail

DAVID MCANALLY
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH AND FAMILY SERVICES
275 E. MAIN ST. 6C-C
FRANKFORT, KY 40621

Re: Conditional Acceptance CC2016UL-1

Dear Mr. McAnally

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Aetna Better Health of Kentucky is committed to meeting our obligations. We believe this letter answers your concerns. Should you have any follow up questions or concerns, please feel free to contact me at (502) 719-8809.

Best Regards,

Sabrina Moore
Plan Compliance Officer

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CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

July 23, 2015

Chad Pendleton
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2015PL-1

Dear Mr. Pendleton,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Humana CareSource Health Plan ("Humana") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana. Pursuant to Section 40.4 of the Contract, Humana shall submit to the Department a Corrective Action Plan within ten (10) business days following the date of this notification delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
HU2015PL-1	APPENDIX L. MCO Provider Network File Layout (Effective 11-07-12)	Failure to leave provider license blank if physician is licensed in a state other than Kentucky.

On July 16, 2015, five (5) records submitted by Humana were rejected as follows:

Record 40936: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE. ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

Record 41165: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE. ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

Record 41166: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE. ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

Record 42507: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE. ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

Record 42851: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE. ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

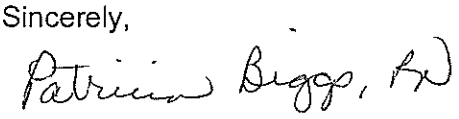
The Office of Administrative and Technology Services (OATS) brought to our attention that Humana continues to send out of state licenses on their provider network file.

APPENDIX L. MCO Provider Network File Layout states: Provider License Character 10 - Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue.

We look forward to receiving Humana's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,



Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
David McAnally, Branch Manager, Managed Care Oversight, Department for Medicaid Services

Corrective Action Plan

Date: August 7, 2015

Topic: Provider License

Unique Identifier: HU2015PL-1

Compliance Regulation/Requirement:

APPENDIX L of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana-CareSource titled "MCO Provider Network File Layout" states: Provider License Character 10 – Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.

Background and Root Cause Analysis:

On July 16, 2015, five records submitted by Humana-CareSource via a file from Beacon, a subcontractor, were rejected for failure to leave provider license blank if a physician is licensed in a state other than Kentucky. The license numbers were entered into the report with all the numbers and characters listed on the license per verification. Beacon had a new employee assisting with the file load who failed to leave the provider license blank.

Summary of actions taken/to be undertaken and completion dates:

Deficiency	Corrective Action	Due Date
Failure to leave provider license blank if a physician is licensed in a state other than Kentucky.	1. Beacon is aware that the limit of licensure numbers is 10 characters and will truncate numbers in order to fit the size limitation per the reporting specifications and requirements under the Contract. Senior staff will review the file load and assist any new employees to ensure compliance with this provision.	Implemented
	2. Beacon will provide training and oversight of staff who are conducting the file load.	Implemented

Certification:

The undersigned have read this Corrective Action Plan and agree to its terms and requirements.

Business Owner Signature: **Date: 8/7/2015**

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

August 17, 2015

Chad Pendleton
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

Re: HU2015PL-1

Dear Mr. Pendleton,

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2015PL-1 (APPENDIX L. MCO Provider Network File Layout (Effective 11-07-12), for failure to leave provider license blank if physician is licensed in a state other than Kentucky.) dated August 7, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above-referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Assistant Director, Managed Care Oversight, Department of Medicaid Services

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

August 5, 2015

Chad Pendleton
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HCS2016IPRO-1 (Revised Version of HCS2014IPRO-1 issued August 5th due 11/4/15)

Dear Mr. Pendleton,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that in order to be compliant with Section 21.5 (EQR Performance) of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana Health Plan (Humana), shall submit to the Department Corrective Action Plans for each deficiency cited below. Plans shall be submitted within 60 days (via certified mail) following the date of this notification delineating the time and manner in which each deficiency is to be corrected. Humana's final resolution of all potential quality concerns shall be completed within six (6) months of Humana's notification.

The SFY 2014 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Humana Minimally or Non-Compliant.

Identifying #	Contract Section	DEFICIENCY
HCS2016IPRO-1	21.5 EQR Performance	The Monitoring Summary page of the report summarizes those areas of the contract that were determined to be out of compliance (and has a specific format for response).

The Corrective Action Plan (utilizing the attached monitoring summary) must fully describe the methodology which accomplishes complete and ongoing corrective action and including:

1. Specific action undertaken to correct an area cited or a deficiency noted;
2. The date a corrective action was/will be initiated; and,
3. The action utilized to assure ongoing compliance.

In order to track Humana's progress in this area, I am asking that Humana give a report on the plan's progress at the Quarterly Quality Meetings and Operations Meeting. Acceptance will be contingent on IPRO's recommendation and the Department's final approval.

Please note that this Summary is assigned a unique identifier. This must be included in any other correspondence concerning these issues. I look forward to receiving Humana's Quarterly Progress Reports and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Judy Baker, Quality and Outcomes Branch, Cabinet for Health and Family Services

B. #CMF09-114A: Monitoring Summary/Corrective Action Plan(s)
Onsite: X

MONITORING SUMMARY/CORRECTIVE ACTION PLAN(S)

1. **Agency Monitored:** Humana CareSource Health Plan
2. **Contract Number(s) / Programs Monitored:** MA 758 1400000426 5, IPRO compliance contract 2014
3. **Monitoring Period:** SFY 2014
4. **Person(s) Conducting Monitoring:** Marydale Coleman and IPRO
5. **Date(s) of Onsite Monitoring:** March 18-19, 2015
6. **Location(s) of Monitoring:** Louisville, KY
7. **Date of Entrance Conference:** March 18, 2015
8. **Persons Present at Entrance Conference:** Janice Acar, Jessica Bielo and April Lathrop
9. **Date of Exit Conference:** March 19, 2015
10. **Persons Present at Exit Conference:** Janice Acar, Jessica Bielo, April Lathrop

FINDINGS OF Minimal and NON – COMPLIANCE/CORRECTIVE ACTION PLANS

Tool #1 Measures and Improvement

Scoring: Minimal

Monitoring Item 1/ Issue: B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data

- *Addressed in the 2014 QI Program Description and QMAC Charter*
- *Specific discussion of and input from members about the Grievance and Appeals process was not found in the QMAC meeting minutes*

Recommendation for Humana
Humana should ensure that the QMAC fulfills all its stated functions, including review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data.

Corrective Action Plan: During the QMAC meeting held on 3/24/15, a presentation was given on the grievance and appeals process and how policies are modified based on grievance and appeals aggregate data.

Date of Planned Implementation: Completed 3/24/15; minutes reported to Quality Assessment Committee 9/7/15.

Monitoring Item 2/ Issue: D. Reviewing Member education materials prepared by the Contractor;
Scoring Minimal

- *Addressed in the 2014 QI Program Description and QMAC Charter*
- *Review of member education materials prepared by the Contractor, other than the Member Handbook, was not found in the QMAC meeting minutes*

Recommendation for Humana
Humana should ensure that the QMAC fulfills all its stated functions, including Reviewing Member education materials prepared by the MCO.

Corrective Action Plan: At the QMAC meeting held on 6/23/15, the New Member Guide (KY-MMED-935) was reviewed with attendees and feedback requested. Going forward, all functions outlined in the QMAC Charter will be addressed at the QMAC throughout the year and documented in the QMAC minutes.

Additionally, a new QI policy (Development of Member Educational Material consistent with Clinical Guidelines) has been developed that includes review by the QMAC committee.

Date of Planned Implementation: Completed 6/23/15; Policy approved by P&P Committee 8/27/15.

Tool # 2 Grievance System

No issues of non-compliance were noted

Tool # 3 Health Risk Assessment

No issues of non-compliance were noted

Tool # 4 Quality Assessment and Performance Improvement: Structure and Operations - Credentialing

No issues of non-compliance were noted

Tool#5 Quality Assessment and Performance Improvement: Access

Scoring: Minimal

Monitoring Item 1/ Issue: All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.

- *The requirement that all information be provided to members in a confidential manner is found in the Member Handbook and the Provider Manual. Missing from the documentation was the regulatory language pertaining to counseling and medical services.*

Recommendation for Humana

Humana should add the regulatory language pertaining to counseling and medical service appointments to its Family Planning Policy as well as to its Provider Manual and Member Handbook.

Corrective Action Plan: An update to the Family Planning Section of the 2015 Member Handbook to include this language has been initiated and will proceed through the appropriate approval process.

Date of Planned Implementation: 12/31/15.

Corrective Action Plan: An update to the 2015 Provider Manual to include this language has been initiated and will proceed through the appropriate approval process.

Date of Planned Implementation: 12/31/15.

Corrective Action Plan: This language will also be included in the future 2016 Provider Manual and Member Handbook.

Date of Planned Implementation: 12/31/16.

Tool # 5a Quality Assessment and Performance Improvement: Access-Utilization Management

Scoring: Minimal

Monitoring Item 1/Issue

The Member's right to request a State hearing;

- *Includes UM file review results*
- *1 of 10 of the UM Files in 2014 included the member's right to request a State hearing*
- *During the onsite interview, the plan explained that a draft of the Notice of Action letter was submitted to the State in October and recently received state approval on 2/6/15. The MCO provided a copy of an email showing denial letter update approved by DMS on 2/6/15.*
- *This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 7, Medical Management – Member- Provider Notification of Initial Determinations on page 4 and Member Denial Letter Update Draft.*

Recommendation for Humana

The initial adverse determination notice should include reference to the member's right to a State hearing.

Corrective Action Plan: The KDMS approved notice (KY-MMED-772) with applicable language regarding a member's right to a State hearing has been implemented and circulated when appropriate.

Date of Planned Implementation: 4/27/15.

Tool # 6 Program Integrity

Scoring: Non-Compliance

Monitoring Item 1 /Issue

K. Upon completion of the PIU's preliminary review, the PIU shall provide the Department and the OIG a copy of their investigative report, which shall contain the following elements:

Any other elements identified by CMS for fraud referral

- *No documentation was submitted to meet this requirement.*
- *This requirement is not addressed in the submitted documentation. A policy and procedure is needed to meet this requirement.*

Corrective Action Plan: The P&P was revised to include all of the elements identified by NBI Medic in the Medicare Managed Care Manual, Chapter 21, and Section 50.7.5. The policy was reviewed and approved by the P&P Committee on 5/28/15.

Date of Planned Implementation: 5/28/15.

Tool # 7 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

No issues of non-compliance were noted

Tool# 10 Case Management/ Care Coordination

No issues of non-compliance were noted

Tool #12a Enrollee Rights and Protection: Enrollee Rights

Scoring: Minimal

Monitoring Item 1 /Issue

30.4 Billing Members for Covered Service

The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.

- *This is not addressed in the Provider Manual. The Member Billing Policy on page 14 in the 2013 provider manual does not contain a statement that any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act.*
- *Humana-CareSource provided a draft revised Provider Manual dated 12-18-14. This manual addresses the federal requirement on page 11. Humana stated that the manual is currently in internal review and will be submitted to DMS for review and approval.*
- *Review determination is minimal because this is a Federal Regulation and the prior year's recommendation was not addressed.*

Recommendation for Humana

Humana-CareSource should complete the internal approval process and then submit the manual to DMS for review and approval

Corrective Action Plan: The 2015 Provider Manual has been updated and submitted to KDMS for approval. Upon approval, the 2015 version will be updated for provider availability.

Date of Planned Implementation: 12/31/15.

Corrective Action Plan: A new SharePoint site is in development that will allow more efficient tracking of all communication submissions to KDMS.

Date of Planned Implementation: 12/31/15.

Tool # 12b Enrollee Rights and Protection: Member Education and Outreach

No issues of non-compliance were noted

Tool # 13 Medical Records

No issues of non-compliance were noted

Tool # 15 Behavior Health Services

No issues of non-compliance were noted

Tool # 16 Pharmacy Benefits

No issues of non-compliance were noted

Executive Director, KY Medicaid 10/13/15

Signature and Job Title **Date**

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

November 2, 2015

Jeff Layman
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HCS2016IPRO-1 (Revised Version of HCS2014IPRO-1 issued August 5th due 11/4/15)

Dear Mr. Layman,

The Division of Program Quality & Outcomes is in receipt of the response developed for HCS2016IPRO-1 (21.5 EQR Performance, for failure to fully comply with Humana CareSource Health Plan's contractual obligations), dated October 13, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above-referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Judy Baker, Quality and Outcomes Branch, Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

September 18, 2015

Chad Pendleton
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016NA-1

Dear Mr. Pendleton,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Humana CareSource Health Plan ("Humana") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana CareSource Health Plan. Pursuant to Section 40.4 of the Contract, Humana shall submit to the Department a Corrective Action Plan within fifteen (15) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
HU2016NA-1	Section 29.7 Provider Program Capacity Demonstration	The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.

The July 2015 Humana Network Adequacy Report shows that Humana Care Source had less than the 25% requirement for specialists for, BHSO without residential services, BHSO including residential Services to all Members, Optician, Endodontist, Professional Art Therapist, Licensed Professional Analyst, Osteopathy, Teleradiologist, Licensed Professional Art Therapist, Licensed Professional Clinical Counselor, Licensed Professional Clinical Group, and Psychologist Group.

According to 29.7 Provider Program Capacity Demonstration Section C of the contract between Humana and DMS, the Contractor shall include in its network Specialists designated by the Department in no fewer number than twenty-five (25%) percent of the Specialists enrolled in the Department's Fee-for-Service program by Medicaid Region; and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Humana's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

Corrective Action Plan

Date: November 4, 2015

Topic: Network Adequacy

Unique Identifier: HU2016NA-1

Compliance Regulation/Requirement:

Section 29.7 ("Provider Program Capacity Demonstration") of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana-CareSource states that "the Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section."

Background:

On September 18th, 2015, the Commonwealth of Kentucky, Department for Medicaid Services ("Department") issued an external CAP based on the July 2015 Network Adequacy Report showed that Humana-CareSource had less than the 25% requirement in the following provider specialties: BHSO without residential services, BHSO including residential services to all members, optician, endodontist, professional art therapist, licensed professional analyst, osteopathy, teleradiologist, licensed professional art therapist, licensed professional clinical counselor, licensed professional clinical group, and psychologist group.

Summary of actions taken/to be undertaken and completion dates:

Deficiency	Corrective Action	Due Date
The July 2015 Network Adequacy Report showed that Humana-CareSource had less than the 25% requirement in the following provider specialties: BHSO without residential services, BHSO including residential services to all members, optician, endodontist, professional art therapist, licensed professional analyst, osteopathy, teleradiologist, licensed professional art therapist, licensed professional clinical counselor, licensed professional clinical group, and psychologist group.	1. Humana-CareSource will continue its ongoing efforts in contracting with new providers to meet network adequacy standards.	On-going
	2. Humana-CareSource will continue to closely monitor network adequacy issues and report out at the monthly operations meeting with the Department.	On-going
	3. Humana-CareSource will continue to work in conjunction with the Department to clarify its entity type, provider type, and specialty coding within the network file sent to the Department to better capture network adequacy.	On-going
	a. Based on the providers listed in the MPL, Humana-CareSource shows adequacy in several of the specialties identified as inadequate. Therefore, Humana-CareSource would like to request a meeting and further guidance from the Department regarding Report 12 specifications and the Department's network file used to determine network adequacy in order to ensure our process is in sync with the contractual requirements.	In process

Certification:

The undersigned have read this Corrective Action Plan and agree to its terms and requirements.

Business Owner Signature:

Date: 11/4/2015

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
Director

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

November 10, 2015

Jeff Layman
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016NA-1

Dear Mr. Layman,

The Division of Program Quality & Outcomes is in receipt of the response developed for ANT2016NA-1 (Section 29.7 Provider Program Capacity Demonstration) dated November 4, 2015.

Please be advised that the response is accepted.

The Department is aware that there are inconsistencies in the reporting and we are working to resolve them. The Department will ensure the MCOs have fifteen (15) business days (after receipt of the Network Adequacy Report) to notify the Department of any deficiencies (noted on the report) the MCO deems that are in error. Please send your rebuttal to Corey Kennedy, the MCO IT box and me. In the absence of a rebuttal from the MCO, the Department may proceed with action under Section 29.10 Expansion and/or Changes in the Network.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

November 2, 2015

Chad Pendleton
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016TPL-1

Dear Mr. Pendleton,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Humana Care Source ("Humana") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana. Pursuant to Section 40.4 of the Contract, Humana shall submit to the Department a Corrective Action Plan within ten (10) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
HU2016TPL-1	Section 21.2 Monitoring Requirements	The Contractor shall cooperate with the Department, its agent and/or Contractor in auditing activity, which may require the Contractor to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans and provide reports as requested by the Department.
	APPENDIX C. THIRD PARTY PAYMENTS/COORDINATION OF BENEFITS. Section I.	To meet the requirements of 42 CFR 433.138 through 433.139, the MCO shall be responsible for: A. Maintaining an MIS that includes: 1. Third Party Liability Resource File

The SFY16 Contract states: The Contractor is responsible for the faithful performance of the contract and shall have internal monitoring procedures and processes in place to ensure compliance. **The Contractor shall fully cooperate with the Department, its agent and/or Contractor in the contract monitoring, which includes but is not limited to: tracking and/or auditing activity, which may require the Contractor to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans, and provide reports as requested by the Department. Cooperation in contract monitoring and provision of documents during contract monitoring will be at no additional cost to the Department.**

The Department has had ongoing issues with Humana submitting the Third Party Liability (TPL) Resource File. The examples are as follows:

- All MCO's were notified in January 2015 via IT conference calls that the TPL Resource File, that was currently due by the 15th of every month, would be due on or before the 8th of every month beginning October 2015. The MCOs were notified numerous times of the date change of the due date change for the TPL Resource file submission after the initial notification in January. On August 13, 2015 an email from IT went out to all MCO's reminding them of the new due date for the TPL Resource File that will be due on or before the 8th of the month beginning October 2015. On the IT minutes from September 1, 2015, Humana stated the TPL file was due by the 8th of the month beginning October 2015 and they were in the processing of making that change. On October 8th, 2015 an email was generated to Humana indicating the TPL Resource file had not been received. No response was received until October 13th, stating the file was sent yesterday the 12th due to the file was scheduled to run on the 15th and the issue had been corrected.

- An email was sent to Humana on July 24, 2015 regarding a member had contacted Humana about updating TPL information and the Humana representative told the member they must contact DMS to get this taken care of. It wasn't until October 12, 2015 that Humana replied back to say that the representative had given incorrect information and was no longer employed by the company.

These deficiencies have the same unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Humana's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality and Outcomes

Corrective Action Plan

Date: November 10, 2015

Topic: Third Party Liability (TPL) Resource File Submission

Unique Identifier: HU2016TPL-1

Summary of Incident: Notification was received from the Department for Medicaid Services ("Department") on October 9, 2015 that the October 2015 TPL Resource file was not received timely on October 8, 2015, the due date for the submission.

On July 24, 2015, the Department sent an email requesting member outreach for a member who was informed by the Humana – CareSource ("HCS") Call Center to contact the Department to update their TPL information. HCS responded on October 12, 2015.

Compliance Regulation/Requirement: Section 21.2 of the Contract states: The Contractor shall cooperate with the Department, its agent and/or Contractor in auditing activity, which may require the Contractor to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans and provide reports as requested by the Department.

See also, Appendix C. Third Party Payments/Coordination of Benefits Section 1.

Root Cause Analysis: The root cause resulting in the October 2015 TPL Resource file not being submitted on October 8, 2015, was due to a human error when the automated file was not updated to reflect the new due date. The automated process generates the TPL Resource file on the 15th of every month and the process was not updated to generate the file on the 8th, pursuant to instruction from the Department.

For Email Response: The October 12, 2015 email from HCS was a follow up to responses that were provided in July regarding the TPL issue of HCS's call center giving incorrect information to a member. On Friday, July 24, 2015, Alisha Clark, of the Department, sent HCS an email requesting member outreach for a member who was incorrectly informed to contact the Department to update TPL information. On July 24, 2015, Teresa Shields, of the Department, sent an additional email to HCS asking to ensure that the HCS call center does not direct members to contact the Department to update their insurance.

That same day, July 24, 2015, Paige Greenwell of HCS responded to Teresa Shields letting her know that the HCS call center had been notified of this policy. On the next business day—Monday, July 27, 2015—Paula Cissell of HCS sent a response to Alisha Clark's email confirming that the member's insurance was updated and outreach had occurred with the member. On July 30, 2015, Patricia Biggs sent a TPL Guidance letter to all MCOs. The member email and TPL Guidance letter was sent to a HCS Compliance Liaison for further investigation. The HCS call center confirmed that the member was provided incorrect information and the representative is no longer with HCS. HCS provided Teresa Shields and Alisha Clark with this update on October 12, 2015. Please see **Attachment A** for email correspondence, which has been edited due to member PHI in original emails.

Summary of actions taken/to be undertaken and completion dates:

Deficiency	Corrective Action	Due Date
Cooperate with the Department, its agent, or Contractor in auditing activity, which may require HCS to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans and provide reports as requested by the Department.	Utilize and update HCS Internal SharePoint site to update requests and review by dates. This will generate reminder emails to be sent to the compliance team member that has been assigned the request. This will help to ensure that timely responses and deliverables are submitted to the Department.	Implemented 11/5/15
Meet the requirements of 42 CFR 433.138 through 433.139 in which the MCO shall be responsible for maintaining an MIS that includes Third Party Liability Resource File.	Update the automated process that created and submitted the TPL file on the 15th of the month to the 8th of every month. November TPL File was submitted successfully on November 8, 2015, please see **Attachment B**.	Completed 10/12/15 Completed 11/8/15

Certification: The undersigned have read this Corrective Action Plan and agree to its terms and requirements.

Business Owner Signature:
Date: November 10, 2015

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

December 3, 2015

Jeff Layman
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

Re: HU2016TPL-1

Dear Mr. Layman,

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016TPL-1 (Section 21.2 Monitoring Requirements and APPENDIX C. THIRD PARTY PAYMENTS / COORDINATION OF BENEFITS. Section I.) dated November 10, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above-referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Managed Care Oversight, Department of Medicaid Services

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

November 9, 2015

Paige Greenwell, Account Executive
Humana CareSource
101 S 5th Street
Louisville, KY 40202

RE: HU2016IPRO-2

Dear Ms. Greenwell:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Humana Care Source ("Humana") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana. Pursuant to Section 40.4 of the Contract, Humana shall submit to the Department a Corrective Action Plan within ten (10) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
HU2016IPRO-2	29.1 Network Providers to be Enrolled	Failure to maintain a network of providers who state that they are accepting new Medicaid patients.
	29.7 Provide Program Capacity Demonstration	Failure to provide covered services to members in a timely manner.

A Review of IPRO's report, *Access and Availability PCP Survey*, August 2015, identified that Humana was non-compliant with the contract sections noted above. The following categories complied with contract obligations <80% of the time: ability to make a routine appointment with PCPs, pediatricians and OB/GYNs within 30 days and ability to make a non-urgent appointment with PCPs, pediatricians and OB/GYNs within 48 hours.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Humana's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

Corrective Action Plan

Date: December 7, 2015

Topic: Network Access and Availability IPRO Survey

Unique Identifier: HU2016IPRO-2

Summary of Incident: Notification was received from the Department for Medicaid Services ("Department") on November 9, 2015, that the 2015 IPRO Access and Availability Survey released on September 2, 2015, revealed that Humana – CareSource (HCS):

1. Failed to meet the 80% benchmark, as set by IPRO, for members to make a routine appointment with PCPs, pediatricians, and OB/GYNs within 30 days;
2. Failed to meet the 80% benchmark, as set by IPRO, for members with non-urgent appointments with PCPs, pediatricians, and OB/GYNs within 48 hours;
3. Had providers responding that they were not accepting new Medicaid members.

Compliance Regulation/Requirement: Contract Section 29.1 Network Providers to Be Enrolled: Failure to maintain a network of providers who state that they are accepting new Medicaid patients and Contract Section 29.7 Provider Program Capacity Demonstration: Failure to provide covered services to members in a timely manner.

Root Cause Analysis: HCS is committed to our ongoing efforts to ensure that our members receive timely and available care. For those providers who responded that they did not have appointments available within 30 days or 48 hours of the request, HCS is investigating these responses to identify reasons why the providers did not have those appointments and send out letters to those providers accordingly. For those providers who responded that they would not accept new Medicaid patients, HCS' records indicate that these providers all had open panels and additional outreach will be provided to those providers reminding them of the necessary notification to HCS if they are no longer accepting HCS members.

Summary of actions taken/to be undertaken and completion dates:

Deficiency	Corrective Action	Due Date
During the IPRO survey, HCS providers stated they were not accepting new Medicaid patients, and did not have appointment times available within the contractual timeframes for routine or urgent visits.	On September 8, 2015, IPRO requested that provider outreach occur. HCS Provider Engagement contacted the providers that IPRO identified. HCS Provider Engagement completed the IPRO spreadsheet and submitted with comments.	Completed- sent spreadsheet to IPRO September 29, 2015
	Research and identify potential causal factors that providers did not have appointments available within 30 days for routine visits and 48 hours for urgent visits.	In process- February 2016
	In response to an HCS conducted survey, the 2014 HCS Provider Access Appointment Availability and After-Hours Audits, HCS sent letters to providers in order determine why contractual requirements were not being met. (KY-P-437)	Completed- Letters sent to identified providers on November 2015
	HCS will modify letter KY-P-437 to be sent to the providers IPRO identified as not having appointments available.	In process- February 2016
	HCS will send a network notification(s) to all providers, including PCP, pediatricians, and OB/GYNs, that will include • Education for providers about the contractual timeframes for setting up routine and urgent appointments. • Education for providers about how to notify HCS when the provider is no longer accepting new Medicaid patients and how to properly notify HCS that their panel is full and needs to be closed.	In process- January 2016
	HCS has an access standards slide on our provider orientation PowerPoint on slide 16. The current PowerPoint can be found https://www.caresource.com/documents/humana-caresource-provider-orientation/.	Completed- March 2015

	HCS will update the current Provider On-Site Visit Form to include access standards including the 30 day routine appointment requirement during Provider Engagement On-Site Visits.	In process- February 2016

Certification: The undersigned have read this Corrective Action Plan and agree to its terms and requirements.

Business Owner Signature:
Date: December 7, 2015

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

Division of Program Quality & Outcomes
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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

Paige Greenwell, Account Executive
Humana CareSource
101 S 5th Street
Louisville, KY 40202

RE: HU2016IPRO-2

Dear Ms. Greenwell:

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016IPRO-2 (29.1 Network Providers to be Enrolled and Section 29.7 Provider Program Capacity Demonstration) dated December 7, 2015.

Please be advised that the response is accepted with the following clarification: The Department of Medicaid Services acknowledges that specifically <80% provider network adequacy is not a contractual requirement. However, the review of IPRO's survey summary report indicates a compliance issue within your network.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
Director

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

November 20, 2015

Jeff Layman
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016DC-1

Dear Mr. Layman

We are writing this Letter of Concern regarding an ongoing issue with your subcontractor, Bright Smiles Dental Care.

Section 22.2 Monitoring Requirements of the contract states: The Contractor is responsible for the faithful performance of the contract and shall have internal monitoring procedures and processes in place to ensure compliance. The Contractor shall fully cooperate with the Department, its agent and/or Contractor in the contract monitoring, which includes but is not limited to: tracking and/or auditing activity, which may require the Contractor to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans and provide reports as requested by the Department of Medicaid Services (DMS).

Section 28.5 Provider Orientation and Education of the contract states: The Contractor shall use reasonable efforts to ensure that all Providers receive targeted education for specific issues identified by the Department. The Contractor shall maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

For approximately 4 months, DMS has received emails and telephone calls from a Humana provider, Bright Smiles Dental Care, requesting that DMS contact Humana because they are not able to get guidance on claims issues. DMS emailed Humana on August 25, 2015 to request that they contact the provider (this email included documentation sent to DMS from the provider). Humana responded and said that they would contact the provider and provide an update. No update was provided. DMS received another call from the provider on September 10, 2015 about these same issues. DMS emailed Humana and requested that they contact the provider and provide an update by COB of September 11, 2015. Humana responded on September 10, 2015 and said they would follow up with the provider and provide an update as requested. No update was given to DMS by the requested date. On October 23, 2015, DMS received another call from the same provider and emailed Humana. In this email, DMS provided Humana with the provider's contact person, phone number, and

another request for an update to explain what Humana had done to resolve the ongoing issues. Humana did not provide a response. DMS sent another email request, on October 26, 2015, for an update due COB on October 27, 2015. Humana then responded on October 27, 2015 and stated that they would provide a response later that day after they gathered information. Humana did respond and said that they had identified the problem and would provide details after their Provider Relations Representative contacted the provider to provide assistance. The last update from Humana was provided on October 28, 2015 and DMS is still not confident that these issues have been completely resolved.

In accordance with Contract Section 40.4(A), we are asking that Humana notify us within two business days of receipt of this letter with a plan. This plan should include an explanation of why these incorrect payments keep occurring, ensuring that they will not continue at the time of your response (or a reasonable timeframe) and preventive measures to ensure future compliance. We look forward to receiving Humana's response and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

November 25, 2015

Via Email

Mr. David McAnally
Branch Manager Managed Care Oversight – Contract Management
Cabinet for Health and Family Services Department for Medicaid Services
275 East Main Street, 6 C-C
Frankfort, KY 40601

Re: HU2016DC-1

Dear Mr. McAnally,

This letter is in response to the Letter of Concern (LOC), received via email on November 23, 2015, regarding Bright Smiles Dental Care ("Bright Smiles") claims payment. The LOC requested Humana – CareSource (HCS) to submit a plan including an explanation of why these incorrect payments are occurring, assurance that this issue will not continue, and a description of preventative measures that will be taken to ensure future compliance.

There were two root causes that caused the issues identified in this LOC:

1. Dental provider network load discrepancies resulting in claims being pended or denied; and
2. Communication breakdowns internal to HCS that resulted in untimely follow-up and communication with Bright Smiles and DMS.

HCS is developing two internal corrective action plans to address these root causes, and will be glad to share them with DMS and provide regular updates as to their effectiveness. At this point, we would like to share what we know about these specific root causes and steps taken to remediate them.

On October 28, 2015, HCS had a call with Bright Smiles during which it was determined that certain individual providers submitting claims from Bright Smiles were not appropriately loaded in our dental provider network system. As a result, these providers appeared as non-participating providers, and their claims were pended or denied. HCS agreed to review these individual dentists to ensure they were loaded into HCS's system so that their claims would be appropriately adjudicated. This analysis showed that seven Bright Smiles providers were not appearing as approved, credentialed providers in the dental provider system. Those names were provided to DMS in our communication on October 28, 2015. Of those seven providers:

- Three providers were present in the system, but data was not complete/accurate, so their claims were being denied as claims from a non-participating provider;
- Two providers did not appear in the system and needed to be loaded;
- One provider did not appear in the system, but had already left Bright Smiles, and therefore needed to be loaded with a term date of 2/12/15; and
- One provider, Dr. Sana Aburob, was not complete/accurate in the dental system so claims were being denied as claims from a non-participating provider. However, claims for this provider should be pended due to an ongoing provider integrity investigation effective June 24, 2014 per a March 13, 2015 communication from DMS. Claims from this provider will continue to pend until DMS provides the outcome of their investigation.

Identified system discrepancies were resolved by a provider load update, and all identified claims were adjudicated from these providers on that date.

On November 23, 2015, HCS contacted Bright Smiles to follow-up and check on remaining claims payment issues and were told that the provider was still seeing payment issues involving one of their two locations. HCS conducted a claims review for that location and identified a provider load issue involving one specific provider, Dr. Sara Jean Paige, who was not loaded into the HCS system. Bright Smiles confirmed that Dr. Paige had been with the practice but left the practice on November 30, 2015. The dental network system will be updated as soon as possible to reflect Dr. Paige's status; we will be able to provide a definitive date next week.

A November 24, 2015 claims report for Bright Smiles, which has been shared with the provider, shows 392 "zero paid" claims, 82 of which are appropriately pended claims for Dr. Aburob (totaling $19,001.70). The remaining 310 "zero paid" claims have been sent to an HCS team of PRR and Claims staff for immediate review to determine if these claims were inappropriately denied due to provider load issues. If so, these claims will be paid with interest as soon as possible. HCS has scheduled a call with our dental network subcontractor for December 2, 2015 to get a more accurate timeline of this claims payment work, and will provide an update in writing next week with a more specific completion date.

We anticipate that, at the latest, Bright Smiles provider load issues will be resolved by a network file update in production by early to mid-December. We will have a more specific date in our next update. Additionally, a work team of HCS and dental subcontractor associates will be created to investigate root causes of dental provider network misalignments and identify more effective oversight controls. In addition, HCS has provided Bright Smiles with the contact number of a dedicated Provider Relations staffer who is aware of these issues and can escalate to senior leadership as needed.

To address the internal HCS communication breakdown, our corrective action plan will include a revision to our formal communications policy and procedure to improve governance of requests from DMS so that meaningful updates are provided in a timely manner. Forwarded emails will now require positive affirmations of receipt, resolution timeframes, and will be standing agenda items on weekly operational calls until resolved. HCS associates involved in this issue will be retrained on the new process and procedure.

Should you have any questions, please do not hesitate to contact me at jlayman@humana.com

Kindest regards,

Jeff Layman
Executive Director, Kentucky Medicaid

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016DC-1

Dear Mr. Layman

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016DC-1 (Section 22.2 Monitoring Requirements and Section 28.5 Provider Orientation and Education) dated November 6, 2015. On December 3, 2015, the Division also received an email from Ms. Paige Greenwell verifying that there were no claims payment issues with Bright Smiles with one exception, the provider that is currently on payment suspension.

Please be advised that the response is accepted. The Division has confirmed that the issues have been resolved and expects updates at your monthly operations meetings.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
Director

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

November 20, 2015

Jeff Layman
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016NA-2

Dear Mr. Layman,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Humana CareSource Health Plan ("Humana") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Humana CareSource Health Plan. Pursuant to Section 40.4 of the Contract, Humana shall submit to the Department a Corrective Action Plan within fifteen (15) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
HU2016NA-2	Section 29.7 Provider Program Capacity Demonstration	The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.

On October 20, 2015, a Humana member contacted the Department and requested disenrollment because Humana did not have an enrolled dental provider available to deliver the needed services. Humana confirmed that no oral surgeon was a network participant.

According to 29.7 Provider Program Capacity Demonstration Section F of the contract between Humana and the Department, access for general dental services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Humana's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

Humana

CareSource

Corrective Action Plan

Date: December 16, 2015

Topic: Disenrollment Network Adequacy

Unique Identifier: HU2016NA-2

Summary of Incident:

Notification was received from the Department for Medicaid Services ("Department") on November 23, 2015 that Humana – CareSource (HCS) was not in compliance with section 29.7 of the Contract after review of a response to a member's request for disenrollment. The member requested to be disenrolled from HCS because they could not find a dental provider in Region 8 to remove impacted wisdom teeth. The Department sent HCS the request for disenrollment on October 23, 2015, and HCS provided a response on October 27, 2015. On October 28, 2015, the Department requested a follow up and a response was provided by HCS on October 29, 2015. A timeline of attempted outreach for the disenrollment of this member is listed below.

Timeline:

On Friday, October 23, 2015, the Department sent HCS a request for disenrollment from a member in Floyd County that was in need of a dental provider for impacted wisdom teeth. Once the request was received, a Call Center Supervisor researched this issue. The Call Center Supervisor attempted to find providers in the member's area. The Supervisor called seven dentists, all of which refer to oral surgeons for wisdom teeth. The Call Center Supervisor performed the following outreach to providers:

Heather Whitt
Big Sandy Public Health Dentistry
7629 KY Route 979
Grethel, KY 41631
FLOYD COUNTY
(606) 587-2800
Provider states they do x-ray to determine if extractions are needed and then will refer to oral surgeon.

Brent G. Clark
11105 US Highway 23 S
Betsy Layne, KY 41605
FLOYD COUNTY
(606) 478-9290
No answer

Quentin T. Robinette
153 Hibbard St
Pikeville, KY 41501
PIKE COUNTY
(606) 437-9942
Spoke with MaryAnne who states they will not take any more HCS members until they get their claims paid.*
*HCS is investigating why this provider stated it was not taking HCS members and will provide outreach if necessary.

Sandra D. Crum-Stevens
6363 KY Route 1428
Allen, KY 41601
FLOYD COUNTY
(606) 949-6971
Provider says they are not taking HCS members anymore because they are not getting paid. Provider stated they have notified their provider rep.*
*HCS is investigating why this provider stated it was not taking HCS members and will provide outreach if necessary.

Ben Whitfield
The Dentist Office, PSC
1144 S Mayo Trl Ste 101
Pikeville, KY 41501
PIKE COUNTY
(606) 433-0033
This provider does not do wisdom tooth extraction.

Joshua R. Raleigh
126 Trivette Dr Ste 201
Pikeville, KY 41501
(606) 432-2773
This provider refers patients to oral surgeon, Chad Street. Dr. Street is non-participating..

Healthy Smiles Family & Cosmetic Dentistry
83 Oak Ridge Ct
Prestonsburg, KY 41653

FLOYD COUNTY
(606) 886-0300
Provider states they do not extract impacted teeth. They refer to Dr. Chad Street.

Chad Street – Non-participating Oral surgeon
129 Loraine St
Pikeville KY 41501
(606) 432-9639
Receptionist is speaking with Dr. Street to see if he would be willing to submit a prior authorization since they are non-participating. Receptionist said she would call back if doctor is willing to submit. Dr. Street's office called back and stated they are not willing to see Humana – Caresource members.

Because the Call Center Supervisor could not locate a participating oral surgeon, the Call Center Supervisor did not contact the member's guardian. On October 27, 2015, HCS provided a response to the Department that stated the dental providers in the area refer to a non-participating oral surgeon, Dr. Chad Street. The Call Center Supervisor did contact Dr. Street's office and confirmed he was not participating and also asked if the provider would be willing to submit a prior authorization since the provider is non-participating. The receptionist stated that she would call back if the provider was willing to submit. On October 28, 2015, the Department requested if any communication had occurred with Dr. Street's office since the last response was submitted on October 27, 2015. On October 29, 2015, HCS informed the Department that Dr. Street's office had not contacted the HCS Call Center.

Compliance Regulation/Requirement:

Contract Section 29.7 Provider Program Capacity Demonstration

The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.

F. Access for general dental services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.

Root Cause Analysis:

HCS is dedicated to our member's dental health and will continue to work towards making improvements in the dental network. A participating oral surgeon could not be located in the member's area to include in the HCS disenrollment response. On October 27, 2015, the Department agreed to allow for four business days to respond to a disenrollment unless there is a dire need situation. This extra time will allow for additional research to occur. HCS is currently working on updating its disenrollment process, as noted in more detail below.

Summary of actions taken/to be undertaken and completion dates:

Deficiency	Corrective Action	Due Date
An oral surgeon could not be located in Region 8 for a member to been seen within the contractual timeframe.	HCS has updated its disenrollment process. Previously, disenrollment requests were researched by one department. Now, in the event that the HCS Call Center cannot find a participating provider for a member, the issue will be escalated to Provider Relations and Medical Management to find a non-participating provider that would be willing to enter into a single case agreement.	11/12/15 Completed
	Effective 1/1/2016 HCS will be partnering with Avesis Third Party Administrators, Inc. (Avesis) for our dental management of Kentucky Medicaid members. The Avesis dental provider network allows us to double our current dental provider network available to members to access as opposed to the previous delegation relationship. This increased dental network will allow members a much broader dental provider selection which will allow access to services closer to home and in a timely manner.	Effective 1/1/2016

Certification: The undersigned have read this Corrective Action Plan and agree to its terms and requirements.

Business Owner Signature:
Date: **December 16, 2015**

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

January 6, 2016

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016NA-2

Dear Mr. Layman

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016NA-2 (Section 29.7 Provider Program Capacity Demonstration) dated November 20, 2015.

Please be advised that the response is accepted upon the following conditions:

According to contract Section 4.3 Delegation of Authority, The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. The Division is requesting a list of the Avesis dental providers (including oral surgeons) in Region 8. This should be submitted to DMS on or before January 15, 2016. The list should include the providers name, specification, and phone number.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016PN-1

Dear Mr. Layman:

We are writing this Letter of Concern regarding the provider network file layout being incorrect as noted by DMS OATS on December 3, 2015.

The Contract states in: APPENDIX D. MANAGEMENT INFORMATION SYSTEM REQUIREMENT, Provider Subsystem, B. Processing Requirements, The Provider Data Maintenance function must have the capabilities to: 1. Transmit a provider enrollment file to the Department in a specific format.

Additionally, the correct provider file layout is as follows:

Provider License	Character	10	Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.

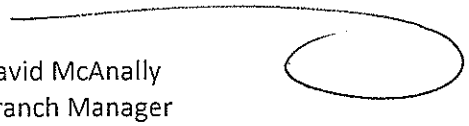
However the file that was received by HP caused an ABEND (abnormally ended) and resulted in the following errors:

- Value used for ROWS parameter changed from 25000 to 1152
- Record 46195: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_LICENSE.
- ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_LICENSE" (actual: 14, maximum: 10)

In accordance with Contract Section 40.4(A), we are asking that Humana notify us within (2) business days of receipt of this letter to review this specific case and let us know how Humana will ensure that this error does not occur in the future.

We look forward to receiving Humana's response and will be available for your questions throughout the process.

Sincerely,



David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality & Outcomes

December 22, 2015

Via Email

Mr. David McAnally
Branch Manager Managed Care Oversight – Contract Management
Cabinet for Health and Family Services Department for Medicaid Services
275 East Main Street, 6 C-C
Frankfort, KY 40601

Re: HU2016PN-1

Dear Mr. McAnally,

This letter is in response to the Letter of Concern (LOC), received via email on December 18, 2015, regarding the provider network file layout not following Appendix D's layout requirements. The LOC requested Humana – CareSource (HCS) to submit a plan including how this will be prevented in the future.

Earlier this year, HCS created a system fix that excluded providers who had more than ten digits in their Kentucky License Number. The providers with over ten digits were to be placed on an exception report, an internal report for errors. For the December Report submission, there was a minor production issue with the system fix as it had gone through environment testing, but was not yet in production.

HCS will ensure that this issue does not occur in the future by confirming the above referenced system fix is in production. HCS is targeting 12/29/15 for the system fix to go into production, which is before the next provider network file is due. Once the system fix is in place, future files will only contain providers with ten digit KY License Numbers.

Should you have any questions, please do not hesitate to contact me at jlayman@humana.com

Humana

CareSource

Kindest regards,

Jeff Layman
Executive Director, Kentucky Medicaid

10200 Forest Green Boulevard Louisville, KY 40223 (502)213-4700

Suite 400

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

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Vickie Yates Brown Glisson
Secretary

January 13, 2016

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

Re: HU2016PN-1

Dear Mr. Layman,

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016PN-1 (Letter of Concern regarding the provider network file layout not following Appendix D's layout requirements) dated December 22, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above-referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Managed Care Oversight, Department of Medicaid Services

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 18, 2015

Paige Greenwell, Account Executive
Humana CareSource
101 S 5th Street
Louisville, KY 40202

RE: HU2016ENC-1

Dear Ms. Greenwell:

We are writing this Letter of Concern regarding a recent report given to us regarding your MCO's November Thresholds (attached). Humana had a total of 4,567 threshold errors.

In accordance with Contract Section 40.4(A), we are asking that Humana notify us within two (2) business days of receipt of this letter with a plan. The plan should include preventive measures to ensure future compliance and a reasonable timeframe.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so may result in your submission being rejected.

We look forward to receiving Humana's response and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

Humana November 2015 Encounter Threshold Errors

Count of NUM_ICN		
ID_MCO	DSC_ERROR_STAT	Total
9900005018	837 ADJ ERR - CLAIM HAS BEEN ADJUSTED	1179
	DETAIL RENDERING TAXONOMY INVALID FOR PROVIDER	841
	NDC NOT ON FILE	283
	NDC IS OBSOLETE - PHARMACY	279
	HEADER RENDERING TAXONOMY INVALID FOR PROVIDER	277
	RENDERING PROV TYPE/CLAIM TYPE INVALID	264
	BILLING PROV NOT ELIG AT SERV LOC FOR PROG BILLED	248
	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP	173
	MEMBER ID NUMBER NOT ON FILE RECYCLE	158
	BILLING PROVIDER TAXONOMY NOT VALID FOR PROVIDER	137
	RENDERING PROVIDER TAXONOMY IS MISSING	117
	NPI ONLY SUBMITTED ON CLAIM - NOT ON FILE - HDR	98
	BILLING PROVIDER TAXONOMY IS MISSING	89
	MEMBER COVERED BY MEDICARE B (NO ATTACHMENT)	49
	NDC MISSING	48
	Member is Dis-enrolled due to Address Mismatch	47
	BILLING PROV NPI NOT ELIG FOR CLAIM DOS	42
	ADJ ERR-CURRENT CLAIM TYPE NOT MATCHING ORIG	39
	837 ADJ ERR - MATCHING CLAIM NOT FOUND	36
	NDC IS REQUIRED FOR THIS PROCEDURE CODE	34
	QUANTITY DISPENSED IS MISSING	33
	837 ADJ ERR-PROV TAXNMY/ZIP NOT MATCHING ORIG	28
	TYPE OF BILL INVALID FOR CLAIM TYPE	13
	MCO PAID AMOUNT MISSING OR NOT GREATER THAN ZERO	12
	TYPE OF BILL INVALID	10
	NDC IS TERMINATED	10
	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	9
	NDC IS OBSOLETE	7
	CANNOT DETERMINE MEDICAID NBR FOR BILLING PROVIDER	4
	837 ADJ ERR - UNABLE TO FIND ORIGINAL ICN	2
	Member Eligibility Suspended Due to Incarceration	1
9900005018 Total		4567

December 23, 2015

Via Email

Mr. David McAnally
Branch Manager Managed Care Oversight – Contract Management
Cabinet for Health and Family Services Department for Medicaid Services
275 East Main Street, 6 C-C
Frankfort, KY 40601

Re: HU2016ENC-1

Dear Mr. McAnally,

This letter is in response to the Letter of Concern (LOC), received via email on December 21, 2015, regarding the November Encounter threshold errors. The LOC requested Humana – CareSource (HCS) to submit a plan including preventive measures to ensure future compliance.

For November, HCS submitted 616,991 encounters to the Department. Of those November encounters submitted, 4567 rejected for threshold errors. Please see the enhancements below to mitigate rejections from occurring in the future. The bullet points direct you to which specific threshold error this enhancement will benefit:

- In process of reviewing our systematically and manually adjusted correct claims process. Based on the feedback from the October 15, 2015, MCO Encounter Technical Workgroup, HCS will enhance our encounters logic to ensure we are following the Department's expectations with regards to the submission of adjustments, voids and resubmissions. Target implementation is 1st quarter of 2016.
    - ADJ-ERR Claim has been adjusted

- In process of implementing the use of 'K3' and 'NTE' to reflect full and partially denied claims from a HCS perspective. This will include representation for claims in which we have

coordinated benefits with another payer and HCS portion reflects a paid amount of $0.00 – since these claims are represented as 'originals' vs. 'denials'. Target implementation is 1st quarter of 2016.

- MCO paid amount missing or not greater than zero

- In process of automating NDC code validation against *First Data Bank.* Target implementation is 1st quarter of 2016.
  - NDC not on file
  - NDC is obsolete – Pharmacy
  - NDC missing
  - NDC is required for this procedure code
  - NDC is terminated
  - NDC is obsolete

- In process of enhancing our current logic which validates against the claim type/provider type crosswalk as well as the group/member crosswalk. Target implementation is 1st quarter of 2016.
  - Billing provider not eligible to bill this claim type
  - Rendering provider type/claim type invalid
  - Type of bill invalid for claim type
  - Type of bill invalid

- In process of enhancing our database to accommodate decimal units. Target implementation is 1st quarter of 2016.
  - Detail units of service must be greater than zero

- In process of enhancing our current logic to check provider information against the Master Provider List (MPL) both on the date in which we receive the claim as well as the date in which we make payment on the claim. Target implementation is 2nd quarter of 2016.
  - Detail rendering taxonomy invalid for provider
  - Header rendering taxonomy invalid for provider
  - Billing provider not eligible at service location for program billed

- Billing provider taxonomy not valid for provider
- Billing provider NPI not eligible for claim DOS
- NPI only submitted on claim – not on file
- Cannot determine Medicaid NBR for billing provider

❖ In process of working internally to ensure member data is loaded accurately and in a timely manner to ensure claims are not paid incorrectly for members who are ineligible for benefits for a specific date of service. Target implementation is 2nd quarter of 2016.

- Member ID number not on file recycle
- Member is dis-enrolled due to address mismatch
- Member eligibility suspended due to incarceration

❖ In process of working internally to ensure coordination of benefits pertaining to Medicare are entered accurately and in a timely manner. Target implementation is 2nd quarter of 2016.

- Member covered by Medicare B

❖ Due to recent enhancements to our data validation, some information is not matching the original information submitted in the encounter files which was represented incorrectly. We are in the process of enhancing our logic to ensure data submitted with a claim frequency code of '7' or '8' reflect the same member/provider information represented on the original encounter. Target implementation is 2nd quarter of 2016.

- ADJ-ERR Provider taxonomy/zip not matching original
- ADJ-ERR Unable to find original ICN
- ADJ-ERR Matching claim not found
- ADJ-ERR Current claim type not matching original

❖ In process of researching claims which are accepted via our automated processing which have invalid or missing data. After the root cause is determined, HCS will work towards implementing a solution to correct this issue.

- Rendering provider taxonomy is missing
- Billing provider taxonomy is missing

- Quantity dispensed is missing

In addition, to the above enhancements, some rejections cannot be corrected based on other contractual requirements or the Department's Encounter Rules, please see instances below:

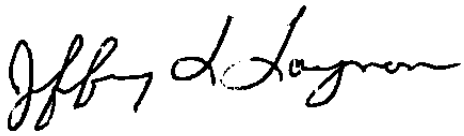
- Per the Department's requirement: When we have made payment in error, we must provide a 30 day recoupment notice. This limits the possibility to correct and resubmit in a timely manner.

- Due to the Department not allowing voids or adjustments for previously rejected encounters, as well as, not allowing denied claims to be sent as resubmissions, it is very difficult to correct our errors if they are due to provider, member or claim type rejections.

- Due to the Department's encounter system not purging until 45 days aged, it is difficult to resend voids and adjustments in a timely manner.

HCS is dedicated to improving our systems to ensure that Encounters are accepting and will continue to work with the Department to achieve encounter acceptance. Should you have any questions, please do not hesitate to contact me at jlayman@humana.com

Kindest regards,



Jeff Layman
Executive Director, Kentucky Medicaid

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
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Vickie Yates Brown Glisson
Secretary

January 13, 2016

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

Re: HU2016ENC-1

Dear Mr. Layman,

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016ENC-1 (Letter of Concern regarding a recent report given to us regarding your MCO's November Thresholds) dated December 23, 2015.

Please be advised that the response is accepted.

If we may be of any additional assistance, please feel free to contact me at the above referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch

cc: Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Vickie Yates Brown Glisson
Secretary

Veronica L. Judy-Cecil
Acting Commissioner

January 21, 2016

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016CS-1

Dear Mr. Layman:

We are writing this Letter of Concern regarding Humana's process for paying claims for diabetic supplies for dual eligible members (information attached from provider). Please note these are covered services under Contract Section 31.1 Medicaid Covered Services and the expectation from the Department is your MCO would instruct the provider on how to have their claims paid (Section 28.0 Provider Services).

In accordance with Contract Section 40.4(A), we are asking that Humana notify us within two (2) business days of receipt of this letter with a plan. The plan should include preventive measures to ensure future compliance and a reasonable timeframe.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so may result in your submission being rejected.

We look forward to receiving Humana's response and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Veronica L. Judy-Cecil, Acting Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

January 25, 2016

Via Email

Mr. David McAnally
Branch Manager Managed Care Oversight – Contract Management
Cabinet for Health and Family Services Department for Medicaid Services
275 East Main Street, 6 C-C
Frankfort, KY 40601

Re: HU2016CS-1

Dear Mr. McAnally,

This letter is in response to the Letter of Concern (LOC), received via email on January 21, 2016, regarding a provider whose claims for diabetic supplies for dual eligible members were denied. The LOC requested Humana – CareSource (HCS) to submit a plan to ensure future compliance with a reasonable timeframe.

HCS was initially made aware of this issue related to payment of diabetic supplies on December 22, 2015 by a DMS request to reach out to Rosemary Smith at Jackson Apothecary/Jordan Drug regarding the following codes:

1. J7620 (Iprat-Albuterol)
2. Q0513 (dispensing fee)
3. A4253 (test strips)
4. A4259 (lancets)

After multiple calls and communications with the provider and DMS (see Timeline Attachment A), HCS identified the root cause for DME claims to deny for dual eligible members was the HCS claims processing system was configured to pay these claims under the pharmacy benefit as opposed to a DME benefit.

On January 13, 2016, a conference call occurred between the provider, HCS and DMS. During the call, Jan Thornton confirmed that all codes for dual eligible members are found on the DME fee schedule. The codes are referenced in a policy issued by DMS in 2010 to clarify that dual eligible claims should process through DME and not through pharmacy. Ms. Smith confirmed she would fax the policy to the HCS Claims Department. The HCS Claims Representative provided her fax and email to Ms. Smith. The HCS Claims Representative confirmed that she would work with HCS Configuration to allow claims to be submitted through DME. This process did not have an ETA, but it was to be a priority. The claims are to be reprocessed back to go live date of January 1, 2013.

In order to properly comply with the requirements for the DME supplies for Dual Eligible members, the HCS Configuration Department is in process of updating the claims system with the appropriate and corrected coding. The target completion date for updating the claims processing system is February 15, 2016. HCS will configure and perform all appropriate tests before final deployment to the claims processing system. Once the changes are implemented, HCS will identify the impacted claims and make necessary adjustments. At this time, HCS does not have the number of claims that have been impacted by this coding update. HCS will follow up with DMS during the week of February 1, 2016 with the estimated count of impacted claims.

Should you have any questions, please do not hesitate to contact me at jlayman@humana.com

Kindest regards,

Jeff Layman
Executive Director, Kentucky Medicaid

Humana CareSource

Attachment A

On December 22, 2015, HCS received a request to outreach to Jackson Apothecary/Jordan Drug to set up a conference call with the provider and Jan Thornton of DMS. The provider was requesting a conference call to discuss outstanding dual eligible member/ diabetic supply services claims. Please see the below procedure codes that were being denied for our dual-eligible patients:

Ms. Thornton requested a response, the next day, December 23, 2015. On December 23, 2015, Paige Greenwell sent Ms. Thornton two emails for this request. The first email was to inform Ms. Thornton that HCS Provider Relations emailed the provider to find what time would be best for the provider to have a phone call. Additionally, HCS Provider Relations requested additional information from the provider to ensure HCS could research the provider's issues.

The second email confirmed that contact was made with the provider via email and phone. During the outreach, the point of contact for the provider, Rosemary Smith, was out of the office and had left for the day. The HCS Provider Relations Representative spoke with Barb Brandenburg and requested the phone call be the second week of January. Ms. Brandenburg stated that the second week of January would be fine, but she was unable to choose a specific time or date because Ms. Smith was not available. Ms. Brandenburg stated she would have Ms. Smith contact HCS to discuss a specific time and date.

On December 28, 2015, Ms. Thornton asked HCS to keep her included in this request. On January 6, 2016, a HCS Provider Relations Representative reached out to Ms. Smith, but she was not in the office. On January 8, 2016, Ms. Smith confirmed with HCS that Wednesday January 13, 2016 at 10:00 would work for the provider's office. The meeting was scheduled and the provider's office and Ms. Thornton were included on the invite.

On January 13, 2016, the conference call occurred. During the call, Ms. Thornton confirmed that all codes for dual eligible members are found on the DME fee schedule. The codes are referenced in a policy issued by DMS in 2010 to clarify that dual eligible claims should process through DME and not through pharmacy. Ms. Smith confirmed she would fax the policy to the

HCS Claims Department. The HCS Claims Representative provided her fax and email to Ms. Smith. The HCS Claims Representative confirmed that she would work with HCS Configuration to allow claims to be submitted through DME. This process did not have an ETA, but it was to be a priority. The claims are to be reprocessed back to go live date of January 1, 2013.

Ms. Thornton stated that a meeting between DMS policy and this provider was scheduled for Thursday January 14, 2016 and would communicate any changes that may occur as a result of that meeting. Ms. Thornton confirmed that she would look into HP's process to find out how they process these claims and submit them to the MCO. For codes A5500 and A5512 on claims will not show up as denied in the system as HCS was paying them at 65% of the fee schedule until recently. HCS Claims requested Ms. Smith provides an example of one of these claims for research. HCS Claims will work with Provider Relations in order to communicate to the provider when the system has been configured.

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

Division of Program Quality & Outcomes
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Vickie Yates Brown Glisson
Secretary

Veronica L. Judy-Cecil
Acting Commissioner

February 2, 2016

Jeff Layman, Executive Director
Humana CareSource Health Plan
101 South 5th Street
Louisville, KY 40202

RE: HU2016CS-1

Dear Mr. Layman

The Division of Program Quality & Outcomes is in receipt of the response developed for HU2016CS-1 (Letter of Concern regarding Humana's process for paying claims for diabetic supplies for dual eligible members) dated January 25, 2016.

Please be advised that the response is accepted upon the following conditions:

Humana must provide DMS with the number of claims impacted and the total dollar amount of these claims. Humana must also provide DMS with a plan of how this system configuration will be implemented and the outcomes of claims that will have to be reprocessed from back to January 1, 2013. Please provide this information to DMS by February 29, 2016.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch

cc: Veronica L. Judy-Cecil, Acting Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes

February 29, 2016

Via Email

Mr. David McAnally
Branch Manager Managed Care Oversight – Contract Management
Cabinet for Health and Family Services Department for Medicaid Services
275 East Main Street, 6 C-C
Frankfort, KY 40601

Re: HU2016CS-1 Conditional Acceptance Response

Dear Mr. McAnally,

This letter is in response to the Conditional Acceptance Letter, received via email on February 3, 2016, regarding a provider whose claims for diabetic supplies for dual eligible members were denied. The letter requested Humana – CareSource (HCS) to provide the following additional information.

Total number of claims impacted and Total dollar amount of claims:

The total number of claims impacted is 1,218 and the number of impacted providers is 246. The total dollar amount of the impacted claims is $27,169.79.

Plan of how the system configuration will be implemented and outcomes of claims that will have to be reprocessed from back to 2013:

On February 3, 2016, the configuration changes were made and an impact report was sent to the HCS Claims department for reprocessing. The configuration plan included identifying the codes that needed to be updated in our system. Those codes are identified below to change into our system as payable on the medical side:

- A4206, A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607, E2100, J7620, Q0513, A5500, A5501, A5503, A5504, A5505, A5506, A5507, A5508, A5510, A5512 as payable.

HCS Configuration updated the HCS system and the following are the ways the HCS has been updated. DME agreements in the HCS system to add the codes identified above to the DME Fee Schedule in the HCS system. Qualifier groups were updated to identify diabetic codes, which including pricing the above codes to ensure the CPT code groupings were included in the HCS system to ensure payment. The above codes were changed to pay under the pharmacy benefit to pay under DME for dual eligible members.

The above configuration updates have been put into place, a Mass Claims Adjustment report was ran on February 23, 2016. The claims that did not process for various reasons have been manually reprocessed.

Should you have any questions, please do not hesitate to contact me at jlayman@humana.com

Kindest regards,

Jeff Layman
Executive Director, Kentucky Medicaid

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Patricia Biggs
Director

Division of Program Quality & Outcomes
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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

July 27, 2015

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Re: PP2015ESE-2

Dear Mr. Carter,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Passport Health Plan is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Passport Health Plan. Pursuant to Section 39.4 of the Contract, Passport Health Plan shall submit to the Department a Corrective Action Plan within ten (10) business days following the date of this notification delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
PP2015ESE-2	4.3 Delegations of Authority	Failure of the Contractor to oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor.
	17.1 Encounter Data Submission	Failure to submit accurate Encounter Data

On Monday, 7/13/15, the full production File KYW837D_9900005016_R_20150617_170601.zip failed and no acknowledgement was requested. The file failed at the TA1 level. The ISA control number in the header and trailer do not match. No TA1 was sent due to it not being requested in the file.

Section 4.3 of the Contract states, "The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor". As you are aware this was a subcontractor productions file.

Additionally, Section 17.1 Encounter Data Submission of the Contract states, "The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department."

Please note Passport has had the following actions occur in FY15 relating to the above referenced contractual citations:

Type of Letter	Description	ID Number
LOC	Subcontractor encounters	PHP2014ES-2
CAP	Failure to submit accurate encounters	PP2015ESE-1
CAP	Encounters Password Protected	PP2015ESE-2
CAP	Subcontractor Oversight- Test File	PP2015SCT-1

Please note that should Passport be unable to be in substantial compliance with Section 4.3 and Section 17.1 (citation FY15 Contract), that the Department will take action under Section 40.4 Requirement of Corrective Action and 40.6 Notice of Contractor Breach (citation FY16 Contract).

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Passport's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

Patricia Biggs, RN

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
David McAnally, Branch Manager, Managed Care Oversight, Department for Medicaid Services

PASSPORT HEALTH PLAN

5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
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WWW.PASSPORTHEALTHPLAN.COM

August 10, 2015

Patricia G. Biggs, RN CPC, CPMA
Division Director
Program Quality and Outcomes
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6C-C
Frankfort, KY 40621

RE: PP2015ESE-2

Ms. Biggs:

Passport Health Plan has reviewed the Department for Medicaid Services' concern expressed in its letter dated July 27, 2015 regarding the above subject CAP. Based on our review, we determined that this was an isolated incident resulting from human error. We have outlined the full details of this situation and our action plan in the attached document.

Please feel free to contact me if you have any questions or need additional information.

Sincerely,

David Henley, JD, CCEP, CHIE, FLMI
Vice President and Chief Compliance Officer

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
David McAnally, Internal Policy Analyst III, Managed Care Oversight – Contract Compliance
Debbie Salleng, Department for Medicaid Services

Enclosure

Action Plan for Accuracy of Encounter Submissions

DMS PP2015ESE-2

Update: August 5, 2015

Summary of Issues and Action Plan:
On June 21, 2015 dental production file KYW837D_9900005016_R_20150617_170601.dat was submitted to the Department for Medicaid Services (DMS). Passport was notified by DMS the following day that the file failed as the ISA control number in the header and trailer did not match.

Passport has put in place an automated process for file validation that includes a review of SNIP and formatting edits. During the file validation process, the error in the ISA control number was identified and the file was removed from the processing cycle. However, prior to correction of the ISA control number, the dental production file was manually inserted back into the processing cycle for transmission to DMS. This was an isolated incident resulting from human error.

The failed file was corrected and resubmitted on June 29, 2015 in file KYW837D_9900005016_R_20150625_080912.zip and was accepted by DMS.

For the last two years there has been increased focus on the improvement of system edits and the encounter build process with our business partners. Significant improvements include: (1) edits that validate the claim/encounter MAID against the DMS provider master file; (2) edits which prevent the payment of duplicate claims; and (3) improvements in the void encounter build process. As a result, our weekly encounter acceptance rate has consistently exceeded 97% since July 1. Acceptance rates have improved over May – 96.6% and June - 95.6%. We also have implemented the actions below to continue to improve the accuracy of encounter submissions and insure response files are requested from DMS. In light of our improvement in our encounter acceptance rate and the process changes we have implemented, we would respectfully request that when the encounter error results from a one-time or human error that DMS would consider either not issuing a CAP to Passport or that DMS would issue a letter of concern rather than a CAP.

Item #	Corrective Action	Completion Date	Status
1.	**Communications with Dental Subcontractor** • Advised subcontractor of error – DMS reported issue within header and trailer not matching causing the file to fail. • ISA Data Element 14 must be completed in order to receive TA1. • Subcontractor making enhancement to system logic to support ISA Data Element 14.	7/31/15	Completed
2.	**Failed Dental File Corrected** • Failed file resubmitted to DMS on 6/29/15 • Attestation was sent to DMS on 7/30/15 documenting resubmission	7/30/15	Completed
3.	**Communication to All Subcontractors** The Interchange Control Header (ISA) Data Element 14 in the ISA Segment of the 837	8/3/15	Completed

	transaction identifies the request for the receipt of an acknowledgment file for the 837 transaction submitted. Each file must have an indicator of "1" in the ISA14 to request receipt of an acknowledgment file.		

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

September 14, 2015

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Re: PP2015ESE-2

Dear Mr. Carter,

The Division of Program Quality & Outcomes is in receipt of the response developed for PP2015ESE-2 (Section 4.3 Delegations of Authority) for failure of the Contractor to oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor and (Section 16.1 Encounter Data Submission) for failure to submit accurate Encounter Data dated August 5, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Assistant Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

September 18, 2015

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Re: PP2016NA-1

Dear Mr. Carter,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Passport Health Plan ("Passport") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Passport Health Plan. Pursuant to Section 40.4 of the Contract, Passport shall submit to the Department a Corrective Action Plan within fifteen (15) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
PP2016NA-1	Section 29.7 Provider Program Capacity Demonstration	The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.

The July 2015 MCO Network Adequacy Report shows that Passport had less than the 25% requirement for specialists for BHSO without residential services, BHSO including residential services to all members, Licensed Professional Art Therapist, and Licensed Behavioral Analyst.

According to 29.7 Provider Program Capacity Demonstration Section C of the contract between Passport and DMS, the Contractor shall include in its network Specialists designated by the Department in no fewer number than twenty-five (25%) percent of the Specialists enrolled in the Department's Fee-for-Service program by Medicaid Region; and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Passport's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

PASSPORT HEALTH PLAN

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October 8, 2015

David McAnally
Branch Manager
Managed Care Oversight – Contract Management
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6C-C
Frankfort, KY 40621

RE: PP2016NA-1 – Provider Program Capacity Demonstration

Dear Mr. McAnally:

This is Passport Health Plan's (Passport) response to the Department for Medicaid Services' (Department) letter dated September 18, 2015. The Department notified Passport it was not in substantial compliance with certain provisions of our Managed Care Contract with the Commonwealth of Kentucky. Specifically, a deficiency in section 29.7 Provider Program Capacity Demonstration was cited for Passport's failure to include in its network no fewer than twenty-five (25%) percent of the Specialists enrolled in the Department's Fee-for-Service program by Medicaid region for the following specialties: BHSO without residential services, BHSO including residential services to all members, Licensed Professional Art Therapist and Licensed Behavioral Analyst.

Passport Health Plan has received and reviewed the notice issued on September 18, 2015 (PP2016NA-1) advising that the July 2015 MCO Network Adequacy Report showed that Passport had less than the 25% requirement for specialists for BHSO without residential services, BHSO including residential services to all members, Licensed Professional Art Therapist, and Licensed Behavioral Analyst. Passport Health Plan submitted BHSO, Licensed Art Therapist, and Licensed Behavioral Analyst via the provider network file for consideration in the July 2015 MCO Network Adequacy Report. These providers were rejected by DMS and sent back to Passport on the Provider Error Network Report with an error indicating "Provider Type not in lookup" or "Provider Primary Spec not in lookup."

Passport acknowledges the member's ability to access services and its responsibility to maintain a network that includes no fewer than 25% of the specialists enrolled in the Department's Fee-for-Service program. Passport alerted DMS to this error in the DMS lookup tables on September 16, 2015 during the PHP IT call and submitted examples to DMS via e-mail that day. Passport did not receive a formal response to this inquiry. However, Passport has continued to submit Behavioral Health Service Organization, Licensed Art Therapist, and Licensed Behavioral Analyst via the provider network file and continued to receive rejections related to errors in the lookup. Passport believes that a technical issue was the cause of the rejected files and that Passport was not responsible for the technical issue.

As of the current adequacy report, released on October 6, 2015, it appears the technical issue has been resolved and Passport is showing adequate on Provider Types 003, 004, 62 and 63. Passport will continue to monitor the provider activity and notify DMS if we identify any potential issues in the future.

Thank you for your consideration of our response above. We respectfully request withdrawal of the initial CAP issued to Passport.

Sincerely,

Christie Spencer
Chief Operating Officer

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes, Department of Medicaid Services
Mark Carter, CEO, Passport Health Plan

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
Director

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

November 10, 2015

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Re: PP2016NA-1

Dear Mr. Carter,

The Division of Program Quality & Outcomes is in receipt of the response developed for PP2016NA-1 (Section 29.7 Provider Program Capacity Demonstration) dated October 8, 2015.

Please be advised that the response is accepted.

The Department is aware that there are inconsistencies in the reporting and we are working to resolve them. The Department will ensure the MCOs have fifteen (15) business days (after receipt of the Network Adequacy Report) to notify the Department of any deficiencies (noted on the report) the MCO deems that are in error. Please send your rebuttal to your liaison, Corey Kennedy, the MCO IT box and me. In the absence of a rebuttal from the MCO, the Department may proceed with action under Section 29.10 Expansion and/or Changes in the Network.

If we may be of any additional assistance, please feel free to contact me.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality and Outcomes

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

October 14, 2014

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Dear Mr. Carter,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that in order to be compliant with Section 21.5 (EQR Performance) of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and University Health Care, Inc. d/b/a Passport Health Plan (Passport), Passport shall submit to the Department Corrective Action Plans for each deficiency cited below. Plans shall be submitted within 60 days following the date of this notification delineating the time and manner in which each deficiency is to be corrected. Passport's final resolution of all potential quality concerns shall be completed within six (6) months of Passport's notification.

The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following areas of Case Management/Care Coordination:

Unique Identifier	Requirements
PHP2014IPRO-CM-1	Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.
PHP2014IPRO-CR-2	In order for Contractor and its Providers to effectively manage care for Members who qualify for School-Based Services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.

PHP2014IPRO-CM-3	Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.
PHP2014IPRO-CM-4	The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.
PHP2014IPRO-CM-5	School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.

I am aware that Passport may have submitted Corrective Action Plans to IPRO in an effort to correct these deficiencies. Upon IPRO's recommendation, DMS will accept those plans and I encourage you to implement them in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

Please note that each issue is assigned a unique identifier. This must be included in in any other correspondence concerning these issues. I look forward to receiving Passport's Quarterly Progress Reports and will be available for your questions throughout the process.

Sincerely,

Patricia Biggs, RN

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

October 14, 2014

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Dear Mr. Carter,

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that in order to be compliant with Section 21.5 (EQR Performance) of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and University Health Care, Inc. d/b/a Passport Health Plan (Passport), Passport shall submit to the Department Corrective Action Plans for each deficiency cited below. Plans shall be submitted within 60 days following the date of this notification delineating the time and manner in which each deficiency is to be corrected. Passport's final resolution of all potential quality concerns shall be completed within six (6) months of Passport's notification.

The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following areas of Case Management/Care Coordination:

Unique Identifier	Requirements
PHP2014IPRO-CM-1	Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.
PHP2014IPRO-CR-2	In order for Contractor and its Providers to effectively manage care for Members who qualify for School-Based Services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.

PHP2014IPRO-CM-3	Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.
PHP2014IPRO-CM-4	The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.
PHP2014IPRO-CM-5	School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.

I am aware that Passport may have submitted Corrective Action Plans to IPRO in an effort to correct these deficiencies. Upon IPRO's recommendation, DMS will accept those plans and I encourage you to implement them in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

Please note that each issue is assigned a unique identifier. This must be included in in any other correspondence concerning these issues. I look forward to receiving Passport's Quarterly Progress Reports and will be available for your questions throughout the process.

Sincerely,

Patricia Biggs, RN

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

October 14, 2014

Mark Carter
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Non-Compliant in the following area of Quality Assessment and Performance Improvement – Utilization Management:

Unique Identifier	Requirements
PHP2014IPRO-UM-1	The Contractor shall submit its request to change any prior authorization requirement to the Department for review.

The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following area of Quality Assessment and Performance Improvement – Utilization Management:

Unique Identifier	Requirements
PHP2014IPRO-UM-2	A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities. The description shall include policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;

I am aware that Passport may have submitted Corrective Action Plans to IPRO in an effort to correct these deficiencies. Upon IPRO's recommendation, DMS will accept those plans and I encourage you to implement them in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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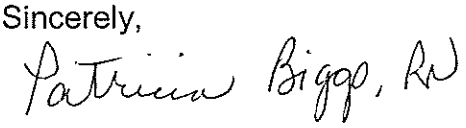

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

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October 14, 2014

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following area of Medical Records:

Unique Identifier	Requirements
PHP2014IPRO-MR-1	The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.

I am aware that Passport may have submitted a Corrective Action Plan to IPRO in an effort to correct this deficiency. Upon IPRO's recommendation, DMS will accept this plans and I encourage you to implement it in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

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October 14, 2014

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5100 Commerce Crossing Drive
Louisville, KY 40229

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following areas of Quality Assessment and Performance Improvement: Measurement and Improvement:

Unique Identifier	Requirements
PHP2014IPRO-MI-1	For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.
PHP2014IPRO-MI-2	Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include: Reviewing Member education materials prepared by the Contractor;

I am aware that Passport may have submitted Corrective Action Plans to IPRO in an effort to correct these deficiencies. Upon IPRO's recommendation, DMS will accept those plans and I encourage you to implement them in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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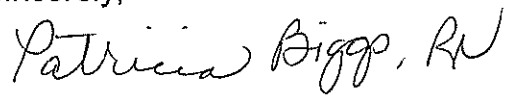

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

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October 14, 2014

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Non-Compliant in the following area of Quality Assessment and Performance Improvement - Access:

Unique Identifier	Requirements
PHP2014IPRO-AC-1	Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.

I am aware that Passport may have submitted a Corrective Action Plan to IPRO in an effort to correct this deficiency. Upon IPRO's recommendation, DMS will accept this plan and I encourage you to implement it in order to become fully compliant with the Contract

and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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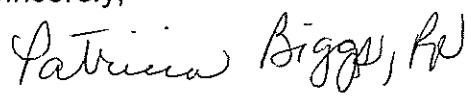

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Non-Compliant in the following area of Behavior Health Services:

Unique Identifier	Requirements
PHP2014IPRO-BH-1	The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.

I am aware that Passport may have submitted a Corrective Action Plan to IPRO in an effort to correct this deficiency. Upon IPRO's recommendation, DMS will accept this plan and I encourage you to implement it in order to become fully compliant with the Contract

and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

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October 14, 2014

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The 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department found Passport Minimally Compliant in the following areas of Grievance System:

Unique Identifier	Requirements
PHP2014IPRO-GS-1	All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.
PHP2014IPRO-GS-2	Documentation regarding the grievance shall be made available to the Member, if requested.

I am aware that Passport may have submitted Corrective Action Plans to IPRO in an effort to correct these deficiencies. Upon IPRO's recommendation, DMS will accept those plans and I encourage you to implement them in order to become fully compliant with the Contract and Federal Regulations. In order to track Passport's progress in this area, I am asking that Passport give a report on the plan's progress at the Quarterly Quality Meetings.

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Sincerely,

Patricia Biggs, RN

Patricia Biggs, R.N., C.P.C.
Director of Program Quality and Outcomes
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Manager, Managed Care Oversight, Department for Medicaid Services

PASSPORT HEALTH PLAN

5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

RECEIVED
APR 06 2015
DEPARTMENT FOR MEDICAID SERVICES

March 31, 2015

Patricia G. Biggs, RN CPC, CPMA
Division Director
Program Quality and Outcomes
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6C-C
Frankfort, KY 40621

RE: 2014 IPRO Compliance Review – Correction Action Plans – Closure Request (2013 Review Period) PHP2014IPRO-MI-1, PHP2014IPRO-MI-2, PHP2014IPRO-GS-1, PHP2014IPRO-GS-2, PHP2014IPRO-CR-1, PHP2014IPRO-CR-2, PHP2014IPRO-AC-1, PHPH2014IPRO-UM-1, PHP2014IPRO-UM-2, PHP2014IPRO-CM-1, PHP2014IPRO-CR-2, PHP2014IPRO-CM-3, PHP2014IPRO-CM-4, PHP2014IPRO-CM-5, PHP2014IPRO-MR-1, PHP2014IPRO-BH-1

Dear Ms. Biggs:

This letter represents Passport Health Plan's (Passport) request for closure of the above-referenced Corrective Action Plans (CAP) which were issued by the Department for Medicaid Services' (Department) letter dated October 14, 2014.

The Department accepted Passport's CAP proposal dated December 15, 2014 which included a deadline for completion of certain actions no later than March 31, 2015. All documentation of Passport's completion of the required actions has previously been submitted with the exception of PHP2014IPRO-CM2 (listed as PHP2014IPRO-CR-2 on the Department's original letter) relating to coordination of care for Members who qualify for School-Based Services. Passport is submitting* today through the IPRO web portal and will upload tomorrow via SharePoint, along with a copy of this letter, the remaining documentation for PHP2014IPRO-CM2.

In anticipation of the Department's and IPRO's acceptance of this documentation as Passport's compliance, Passport respectively requests written notification of closure of the above-referenced CAPs.

If you have questions or need additional information, please let me know.

Sincerely,

Kim Myers, CHPC, CCEP
Compliance Director and Privacy Officer

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Elizabeth Justus, Director of Policy and Operations, Department for Medicaid Services
Mark Carter, CEO, Passport Health Plan
David Henley, VP and CCO, Passport Health Plan
Christie Spencer, VP, Operations, Passport Health Plan

* The materials submitted are proprietary and confidential and we request that they be utilized accordingly.

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Cindy Arflack
Director

Division of Program Quality & Outcomes
275 E. Main Street, 6C-C
Frankfort, KY 40621
(502) 564-9444
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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

October 22, 2015

David Henley, VP & Chief Compliance Officer
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

RE: PP2016PAS-1

Dear Mr. Henley:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Passport Health Plan ("Passport") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Passport. Pursuant to Section 40.4 of the Contract, Passport shall submit to the Department a Corrective Action Plan within ten (10) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited below is to be corrected.

Identifying #	Contract Section	DEFICIENCY
PP2016PAS-1	15.1 Contractor Management information System	Failure to provide adequate support for all aspects of a managed care operation and subsystems recognizing prior approvals in claims.

On October 2, 2015, DMS sent an email to Passport noting that it had received a referral from the Department of Insurance prompt-pay group that appeared to have been recurring for over 6 months. The Department was concerned that there had been numerous attempts by the provider to resolve the problem to no avail. The provider stated that many claims were being denied for no prior authorization (PA) when the claim clearly contained a PA number. The Department's' research supports that assertion. Example from Associates in Pediatric Therapy: On their 9/29/2015 report to the Department of outstanding Passport claims, 153 were unpaid because they were denied for no PA. The monetary total of those claims was $22,800.00.

Please note this deficiency has been assigned a unique identifier. Include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Passport's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

PASSPORT HEALTH PLAN

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502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

October 30, 2015

David McAnally, MBA, CPPO, CPPB
Branch Manager
Managed Care Oversight – Contract Management
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6C-C
Frankfort, Kentucky 40621

RE: PP2016PAS-1

Dear Mr. McAnally:

This is Passport Health Plan's (Passport) response to the Department for Medicaid Services' (Department) letter dated October 22, 2015. The Department notified Passport that it was not in substantial compliance with certain material provisions of the Managed Care Contract between the Commonwealth of Kentucky and Passport. Specifically, a deficiency in section 15.1 Contractor Management Information System of the contract was cited for Passport's failure to provide adequate support for all aspects of a managed care operation and subsystems recognizing prior approvals in claims.

In August of 2015, we performed an internal review and determined the root cause of the therapy denials was the method in which we were authorizing therapy claims. Actions were taken in August to change the authorization process going forward and monitor denials for several months. Since it is not unusual for therapy authorizations to cover several patient visits over a period of multiple weeks or months, we assessed that the denials might continue for a few months but at a significantly lower rate. Therefore, we provided our claims adjusters with written instructions on how to review therapy claims to reduce the likelihood of claims being denied incorrectly. Also, we established a process to monitor therapy authorization denials and immediately correct them before the claim in finalized.

Passport respectfully proposes the following Corrective Action Plan (CAP) including actions taken to date and future actions:

CORRECTIVE ACTION	MEASUREMENT OF COMPLETION	DATE OF COMPLETION
Therapy authorizations are generated in units (15 minute increments) instead of one per day.	Notification sent to all Utilization Management staff to issue therapy authorizations on a per unit basis rather than one per day.	Effective August 20, 2015, Utilization Management staff are authorizing therapy visits as 4 units per hour.

Passport has completed an audit of all therapy claims denied for no authorization and is reprocessing these claims for payment.*	This audit was sent to Passport's Third Party Administrator for automated reprocessing. Any claims that cannot reprocess through the automated method will be manually reprocessed.	The first phase of this project will be completed by November 20, 2015.
Passport will run a bi-weekly report to identify authorization denials for therapy claims to ensure the new process is working as planned and reprocess claims inappropriately denied.	Once we see that at least 95% of therapy claims are processing correctly, we will discontinue the process of generating and reviewing reports on a bi-weekly schedule.	We expect it to take no longer than six months (i.e., April 30, 2016) to hit the 95% threshold for correct processing of therapy claims,

* Passport has completed an audit of all therapy claims with dates of service from 10/1/2014 through 9/30/2015 for no authorization and is reprocessing these claims for payment.

Based on this proposal and actions that we have taken to date, Passport's new process of authorizing therapy visits reduces the likelihood of incorrect denials and should completely eliminate the issue within six months. During this transition phase, we will continue to monitor denials and reprocess claims that may be based on previous method for authorizing therapy claims. The implementation of this new authorization process creates a more efficient and effective system of claims processing.

Given the above, Passport submits that the deficiency has been corrected and respectfully requests the Department to accept our corrective action plan and close PP2016PAS-1.

Respectfully,

David Henley, JD, CCEP, CHIE, FLMI
Vice President and Chief Compliance Officer

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Cindy Arflack, Assistant Director Managed Care Oversight, Department for Medicaid Services
Debbie Salleng, Policy Analyst, Managed Care Oversight
Mark Carter, Chief Executive Officer, Passport Health Plan

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Cindy Arflack
Director

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

November 23, 2015

David Henley, VP & Chief Compliance Officer
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

RE: PP2016PAS-1

Dear Mr. Henley:

We are in receipt of your Corrective Action Plan (CAP) regarding:

Identifying #	Contract Section	DEFICIENCY
PP2016PAS-1	15.1 Contractor Management Information System	Failure to provide adequate support for all aspects of a managed care operation and subsystems recognizing prior approvals in claims.

After reviewing your MCO's response we are unable to locate a detailed plan (i.e. it is not complete) to ensure future compliance and a reasonable implementation date; therefore, the response is not accepted.

Please ensure your future response includes the following components:

1) A plan to self-report future occurrences on any systemic problems you become aware of that impacts providers to the Division Director, your liaison, and me (i.e. we do not want to discover a systemic problem with an MCO from the provider or member communities).
2) A provision for reaching out to all of the affected therapy providers by telephone **and** letter fully explaining Passport's deficiency and how it is being resolved for their organization. Submit relevant copies of scripts and letters to the Department.
3) Explain the process of how **100%** of the denied claims will be resolved and paid (within a reasonable time frame). This plan should ensure **all denied claims** are fully paid regarding this issue (cradle to grave) with a reconciliation of these claims.
4) Explain how the method assures that inappropriate denials will not persist regardless of when the prior authorization was issued.
5) Provide bi-weekly written updates on the progression of the resolution, to your liaison, Corey Kennedy, Cynthia Lee and me.

Pursuant to Section 40.4 of the Contract, Passport shall submit to the Department, a revised Corrective Action Plan within ten (10) business days following the date of this notification (via certified mail) delineating the time and manner in which each deficiency cited above is to be corrected.

As you are aware this deficiency has been assigned a unique identifier. Please include this number with any correspondence concerning this issue. Failure to do so will result in your submission being rejected.

We look forward to receiving Passport's revised Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

David McAnally
Branch Manager
Managed Care Oversight – Contract Management

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Christina Heavrin, General Counsel, Cabinet for Health and Family Services
Cindy Arflack, Director, Division of Program Quality & Outcomes

PASSPORT HEALTH PLAN

5100 COMMERCE CROSSINGS DRIVE
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WWW.PASSPORTHEALTHPLAN.COM

December 16, 2015

Mr. David McAnally
Branch Manager
Managed Care Oversight – Contract Management
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6C-C
Frankfort, Kentucky 40621

RE: PP2016PAS-1

Dear Mr. McAnally:

This is Passport Health Plan's (Passport) response to the Department for Medicaid Services' (Department) letter dated November 23, 2015. The Corrective Action Plan submitted by Passport on October 30, 2015 was deemed to be incomplete by the Department. Additional actions have been added to this Plan in an effort to comply with the components requested by the Department. Passport was initially cited for a deficiency in section 15.1 Contractor Management Information System of the contract for failure to provide adequate support for all aspects of a managed care operation and subsystems recognizing prior approvals in claims.

In August of 2015, we performed an internal review and determined the root cause of therapy denials was the method in which we were authorizing therapy claims. Actions were taken in August to change the authorization process going forward and monitor denials for several months. Since it is not unusual for therapy authorizations to cover several patient visits over a period of multiple weeks or months, we assessed that the denials might continue for a few months but at a significantly lower rate. Our claims adjusters have written instructions on how to review therapy claims to reduce the likelihood of incorrect denials.

Passport respectfully proposes the following Corrective Action Plan (CAP) including actions taken to date and future actions:

CORRECTIVE ACTION	MEASUREMENT OF COMPLETION	DATE OF COMPLETION	STATUS
Therapy authorizations generated in units (15 minute increments) rather than one per day	Notification sent to all Utilization Management staff to issue therapy authorizations on a per unit basis rather than one per day	Effective August 20, 2015, Utilization Management staff are authorizing therapy visits as 4 units per hour	Complete
Passport communication to all therapy providers informing them of the changes made in the	Written communication sent to all therapy providers. Passport has done telephone outreach	November 10, 2015	Complete

authorization process	to the largest therapy providers and has responded to all inquiries.		
Passport has completed an audit of all therapy claims denied for no authorization and is reprocessing these claims for payment. This audit included claims with dates of service from 10/1/14 through 9/30/15.	This audit was sent to Passport's Third Party Administrator for automated reprocessing. Any claims that cannot reprocess through the automated method will be manually reprocessed.	The first phase of this project will be completed by November 20, 2015.	Complete
Passport will run a bi-weekly report to identify authorization denials for therapy claims to ensure the new process is working as planned and reprocess claims inappropriately denied.	When at least 95% of therapy claims are processing correctly, we will discontinue the process of generating and reviewing reports on a bi-weekly schedule. To achieve the additional 5% accuracy rate would be a hardship on providers and Passport as it would require the reissuance of all outstanding authorizations initially issued prior to August 20, 2015.	We expect it to take no longer than three months (i.e., January 31, 2016) to hit the 95% threshold for correct processing of therapy claims. We have already achieved a 94% acceptance rate during the month of December.	Ongoing Therapy claims adjudicated in the first two weeks of December 2015 show only 6% of claim lines denied for no authorization.
Identification of systemic issues utilizing denial trend reports. Systemic therapy authorization errors will be reported to DMS Division Director of Program Quality & Outcomes, Branch Manager of Managed Care Oversight, and Liaison.	Passport has incorporated monitoring of denials into existing processes for Provider Claims Specialists including outreach to providers and notification to the Supervisor of Provider Claims. Communication of systemic issues will be made to DMS through Passport Compliance Department.	Denial trend report incorporated into Claims workflow by December 16, 2015	Complete

Based on this proposal and actions that we have taken to date, Passport's new process of authorizing therapy visits reduces the likelihood of incorrect denials and should completely eliminate the issue within three months. During this transition phase, we will continue to monitor denials and reprocess claims that may be based on previous method for authorizing therapy claims. The implementation of this new authorization process creates a more efficient and effective system of claims processing.

Passport will provide by-weekly updates of the progression of the resolution of the one outstanding ongoing item.

Given the above, Passport submits that the deficiency has been corrected and respectfully requests the Department to accept our corrective action plan.

Respectfully,

David Henley, JD, CCEP, CHIE, FLMI
Vice President and Chief Compliance Officer

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Cindy Arflack, Director, Division of Program Quality & Outcomes
Debbie Salleng, Policy Analyst, Managed Care Oversight
Mark Carter, Chief Executive Officer, Passport Health Plan

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Cindy Arflack
Director

Division of Program Quality & Outcomes
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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

January 8, 2016

Mark Carter, Executive Director
Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

Re: PP2015PAS-1

Dear Mr. Carter,

The Division of Program Quality & Outcomes is in receipt of the second response developed for PP2015PAS-1 (Section 15.1 Contractor Management Information System) for failure to provide adequate support for all aspects of a managed care operation and subsystems recognizing prior approvals in claims dated November 23, 2015.

Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

David McAnally
Branch Manager, Managed Care Oversight - Contract Oversight Branch
Department for Medicaid Services

cc: Lisa D. Lee, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Assistant Director, Division of Program Quality and Outcomes

PASSPORT HEALTH PLAN

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February 19, 2016

David McAnally
Branch Manager
Managed Care Oversight – Contract Management
Department for Medicaid Services
275 East Main Street, 6C-C
Frankfort, KY 40621

RE: PP2015PAS –1 Contractor Management Information System

Dear Mr. McAnally:

This is Passport Health Plan's ("Passport") update to the Department for Medicaid Services ("Department") regarding the above referenced Corrective Action Plan. Since our initial response to the Department, Passport has been performing audits on the therapy claims which denied for no authorization.

Based upon our review, we have seen a decrease in the number of therapy claims that are denying due to no authorization. To reduce the likelihood that we have missed a therapy claim that was previously denied for no authorization or that therapy claims authorized prior to August 20, 2015 are submitted for processing, we will continue to audit the claims for approximately another two months.

Sincerely,

David Henley, JD, CCEP, CHIE, FLMI
Vice President and Chief Compliance Officer

cc: Veronica L. Judy-Cecil, Acting Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality and Outcomes
Mark Carter, CEO, Passport Health Plan

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March 8, 2016

Mr. David McAnally
Branch Manager
Managed Care Oversight – Contract Management
Division of Program Quality & Outcomes
Department for Medicaid Services
275 East Main Street, 6C-C
Frankfort, KY 40621

RE: PP2016PAS-1 Response to February 22, 2016 email

Dear Mr. McAnally:

This is Passport Health Plan's (Passport) response to the Department for Medicaid Services' (Department) email of February 22, 2016 regarding the above referenced matter. In this email, the Department requested the below information:

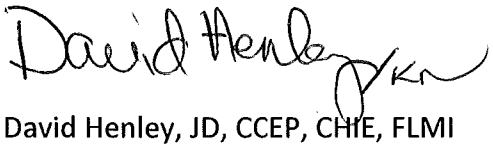
> Please send us information on the error rate on the audits from the time of the Corrective Action Plan to current. Ms. Hayes mentioned the acceptance rate percentage rate after the Encounters Meetings. We also want to know if the error rate are clean claims with a prior authorization that have a systematic issue or they have other errors that result in payment (i.e. properly identify the percentage). Thank you.

On August 20, 2015, Passport changed therapy authorizations from one unit per day to 15-minute units. Since this change, we have continued to monitor therapy claims and reprocess denials that may be based on the previous method for authorizing therapy.

Therapy denials related to authorizations have continued to trend downward and represent 5% of outpatient therapy claim lines adjudicated between 1/1/16 and 2/24/16. Passport will continue to monitor claims denied for no authorization, reprocess claims on a bi-weekly basis when appropriate, and reach out to providers who may have questions concerning our requirements.

Passport respectfully request that this clarifies the above referenced matter and seek to close PP2016PAS-1 if the Department is in agreement. Passport requests a letter of closure for the above or further communication regarding revisions in the event the actions taken to date does not satisfy the Department's requirements.

Sincerely,



David Henley, JD, CCEP, CHIE, FLMI
Vice President and Chief Compliance Officer

cc: Stephen P. Miller, Commissioner, Department for Medicaid Services
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Director, Division of Program Quality & Outcomes
Mark Carter, CEO, Passport Health Plan