

MAC Binder Section 3B – Corrective Action Plans

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**CABINET FOR HEALTH AND FAMILY SERVICES
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September 21, 2015

Sabrina Moore
Terence L. Byrd
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016FC-1

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that CoventryCares of Kentucky ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry Health and Life Insurance Company. Pursuant to Section 39.4 of the Contract, Coventry 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
CC2016FC-1	Section 36.2	Failure to ensure access to care coordination for all DCBS clients.

Attached you will find the recent IPRO report, Subject Name: KENTUCKY MEDICAID MANAGED CARE REVIEW OF COVENTRY CARES DCBS CHILDREN WITH INPATIENT BEHAVIORAL HEALTH DECERTIFICATION SUMMARY REPORT. Your MCO first received this report on 8/19/15 and was requested to respond on or before 9/18/12.

Please note there are four findings associated with this report that require a plan of correction and reasonable implementation date ("time and manner") in Coventry's Response. Please also note that IPRO has recommendations and we would highly recommend your MCO ensure that the response incorporates these recommendations.



Also 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.

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

Sincerely,

A handwritten signature in black ink, consisting of a long horizontal stroke that curves upwards and then loops back down to the right, ending in a small oval shape.

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



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**KENTUCKY MEDICAID MANAGED CARE
REVIEW OF COVENTRY CARES DCBS CHILDREN WITH
INPATIENT BEHAVIORAL HEALTH DECERTIFICATION
SUMMARY REPORT**

FINAL 7-23-15

Introduction

The Kentucky Department for Medicaid Services (DMS) identified a concern related to coordination of care for DCBS foster children enrolled in the Medicaid managed care organization (MCO), CoventryCares of Kentucky. DMS was concerned that CoventryCares does not adequately coordinate care and participate in discharge planning for children with inpatient behavioral health admissions. Additionally, there was concern related to “decertification” or concurrent denials for continued inpatient stay at behavioral health facilities. This is of particular concern for these foster children who have chronic behavioral health conditions and who may be difficult to place. DMS requested that IPRO conduct a review of selected cases of foster children enrolled in CoventryCares with an inpatient behavioral health admission.

Purpose

The purpose of this review was to identify if DMS’ concerns were warranted. IPRO clinical staff reviewed selected cases for appropriateness of MCO care management, coordination of care, continuity of care, and where a potential issue was identified, for utilization management (UM) and/or quality of care (QOC). Cases for review were randomly selected from the DCBS Log(s) of Utilization Management Activity for DCBS Foster Children receiving inpatient behavioral health services. The sample was chosen from the eligible population of members in the log(s).

Methodology

IPRO developed a case review worksheet and selected a sample of five (5) members for the case review. Documentation was requested from the MCO, including the care/case management record(s); DCBS communications and meeting logs (if applicable); and utilization management record(s). Documentation was also obtained from DCBS, including the DCBS “Decertification” log; DCBS case worker notes; and documentation related to any member-specific concerns.

An IPRO Clinical Nurse Reviewer reviewed the MCO and DCBS documentation for each of the five (5) cases for adequacy of MCO care management, coordination of care, continuity of care, and potential UM and/or quality of care (QOC) issues. If a potential issue UM and/or QOC issue was identified, the case would have been referred for physician review. The Managed Care Medical Officer would make the decision regarding the appropriate physician reviewer specialty for referral.

A determination was made regarding whether the care management and coordination of care were adequate; the continuity of care was acceptable; the utilization management process and decisions were appropriate; and if the quality of care was satisfactory.

A case summary report was prepared for each case, including a detailed analysis, the findings, and the rationale for the determinations. This document summarizes the case reviews, provides general findings, and offers recommendations.

Case Summaries

Case #1

Member #1 was a teen with diagnoses of history of neglect and sexual abuse; sexual disorder/deviation; other episodic mood disorder; impulse control disorder; hyperkinesia with developmental delay; mental retardation/IQ 52-55; cerebral palsy; asthma; who was born premature and addicted to cocaine.

Member #1 had 2 admissions during the period reviewed; one psychiatric residential treatment facility (PRTF) sexual offender treatment program (SOTP) admission for 152 days and one out-of-state (OOS) PRTF/inpatient mental health (IPMH) admission for 61 days.

Member #1 was living with adoptive family and was followed by DCBS due to inadequate supervision and hoarding (by adoptive family). Member #1 had incidents of sexual offending against adoptive siblings who were then placed in temporary foster care. Member #1 was removed to PRTF #1, with an estimated length of stay (LOS) of 3-6 months. During PRTF #1 stay, member had inappropriate sexual behaviors, oppositional-defiant behaviors, aggressive and destructive behaviors. Continued stay was denied on the 56th day due to limited progress in therapy with only temporary improvement, with 2 days allowed for discharge planning. An expedited appeal upheld the decision. A subsequent conference call with the MCO, facility #1, and DCBS resulted in the denial being overturned. There was no documentation in the MCO or DCBS records regarding the specifics of this call. The following day, Member #1 committed a sexual offense against a peer. Member #1 continued treatment at PRTF #1 due to lack of appropriate placement options, possible out of state placement, and the need for very close supervision. On the 111th day, continued stay was again denied and the MD reviewer recommended that the member needed a program for low IQ, specifically. An expedited appeal upheld the decision.

Member #1 remained at the facility pending possible placement at an OOS facility. On the 151st day, the admissions department at the OOS facility #2 was contacted. The member was transferred to the OOS facility #2 on the 154th day with an estimated LOS of 30 days and a plan to discharge to adoptive parent. There was some question whether the adoptive parent fully understood the risk of having member in the home and possessed the ability to adequately supervise the member. During this admission, there was a confirmed quality of care issue identified by the MCO. Facility #2 submitted a corrective action plan. On the 61st day, Member #1 was discharged to the adoptive parent with home services and outpatient behavioral health (BH) treatment, including individual and family therapy. Member #1's siblings were living outside the adoptive home but there were suspected incidents of sexual offending against 1 sibling and a peer at school.

DCBS notes demonstrated that the member was followed from prior to the first admission through discharge home with outpatient therapy until 12/2014. MCO notes were initiated at the time of the first admission through 2nd admission but were related solely to utilization review (UR) functions. There was one MCO note after the 2nd discharge, but it was an authorization for outpatient BH therapy only. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no evidence of coordination of care/continuity of care other than utilization management (UM) activities. There was no documentation by the MCO after the member's discharge to the adoptive home, except the outpatient authorization. There was evidence of some participation in discharge planning. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case #2

Member #2 was a teen with diagnoses of sexual offender; unspecified psychosexual disorder; history of possible sexual abuse; impulse control disorder; asthma; and other ill-defined and unknown causes of morbidity and mortality. Member #2 had 3 admissions during the review period; one residential treatment center (RTC) SOTP for > 1 year (~ 16 months), one RTC SOTP for 44 days, and one residential children's center (RCC) with SO treatment for ~ 71 days. The first RTC SOTP admission began prior to enrollment with the MCO; but the member was enrolled in the MCO for 304 days through discharge from this facility. There were only DCBS notes for this portion of the review period.

Member #2 was born to a teen mom, had never met father, raised by grandparents, and had 3 siblings. Member #2 lived with mother, her husband, younger half-sibling and maternal grandparents. During 2012, Member #2 and sibling were placed in State custody due to domestic violence. Foster family raised concerns regarding sexual offending (SO). There was law enforcement/legal involvement. At some point, Member #2 lived with Aunt who denied any SO events. Admitted to facility #1 and failed treatment there with incident(s) of SO against peer(s). Member #2 was transferred from facility #1 to facility #2. Member #2 admitted to RTC SOTP #2 with estimated LOS 9 months and discharge plan of

DCBS placement, Aunt's custody, or with family in Florida. Member made some progress at RTC SOTP #2, but showed disobedience/defiance, inappropriate behaviors, and hoarding. A quality of care issue was confirmed by the MCO at facility #2, with no response from the facility. Continued RTC SOTP #2 stay was denied on day #42 due to lack of medical necessity, not reasonably expected to improve under treatment plan and documentation does not support program protocol, with 2 days for discharge planning. MD reviewer recommended group home setting, outpatient treatment for SO, and family therapy. An expedited appeal was filed, supported by DCBS and DPP, with denial upheld. As a result of the continued stay denial, Member #2 was transferred to RCC with SO treatment on day # 55, with a discharge plan to return to parent or therapeutic foster home. On day #153 the discharge goal was changed to adoption. DCBS notes ended as of 12/2014, with member progressing through the SO program and attending public school and with a discharge plan to either return to parent, foster care, or adoption.

DCBS notes demonstrated that the member was followed from RTC SOTP #1 through end of review period. There were no MCO notes provided for the first admission, although the member was enrolled in the MCO for the majority of that admission. MCO notes were initiated at the time of transfer from RTC SOTP #1 to #2. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. MCO notes were related solely to UR functions. There were no MCO notes after transfer from RTC SOTP #2 to RCC. During the RCC admission, MCO documentation included only an authorization for outpatient BH therapy. There was no evidence of coordination of care/continuity of care other than UM and only for the period during RTC SOTP #2 stay. The member was followed by the MCO only during RTC SOTP #2 stay. Transfer to RCC was the result of denial of continued stay at RTC SOTP #2. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case #3

Member #3 was a teen with diagnoses of bipolar disorder; mild mental retardation/IQ 61; ADHD with hyperactivity; unspecified hyperkinetic syndrome; unspecified disturbance of conduct; anxiety; other specified episodic mood disorder; other unknown and unspecified cause of morbidity and mortality; seizure disorder; rule out medication side effects and akathisia; constipation; and seasonal allergies.

Member #3 had 4 admissions with periods of elopement/away without leave (AWOL) in 2 facilities during the review period: one IPMH admission at facility #1 for 12 days; one admission at facility #2 at both IPMH and PTRF levels of care for 23 days, one admission at facility #2 at both PTRF and IPMH levels of care for 187 days (denied after day #170); and one admission at facility #2 at the PTRF level of care for 54 days (denied in its entirety).

Member #3 was residing at a children's home as a result of being removed from parents' custody due to physical abuse and neglect and relinquishing parental rights in 2009. Siblings remained with one of the parents. Member #3 had been in foster care but family could not meet his/her mental health needs. Member #3 had a prior history of 2 IPMH admissions in 2012. Member #3 was said to be compliant with medications. Member #3 was admitted emergently to IPMH for severe aggression and self harm. MCO note at this time stated "Coordination of Care referral: No." Upon admission, the children's home gave notice that they would not accept the member back upon discharge. MCO note stated that PRTF placement should be considered on discharge and possible placement issues. During this stay, the member was noted to be physically aggressive to staff, peer(s), and self, had destructive behaviors and manic behavior and speech, and continuously described wanting a family. Member #3 transferred to PRTF at facility #2 with an estimated LOS of 6 months and discharge plan "per DCBS". During the stay at facility #2, the member displayed verbal and physical aggression toward staff and peers, destructive behaviors, sexual acting out and was transferred from PRTF to IPMH level of care at facility #2 for 8 days due to suicidal ideation/gesture, homicidal ideation with no plan, multiple elopement incidents, criminal behavior with law enforcement involvement, with a plan to transfer back to PTRF level of care. During the IPMH period, the member had manic behavior and reported visual and auditory hallucinations. The MCO noted telephone outreach DCBS at this time. There was a gap in the MCO documentation for 3 days during this IPMH admission and authorization information was not available. MCO notes resumed with the IPMH admission to facility #2. The notes indicated that the member was AWOL from PTRF and displayed physical aggression toward staff requiring injected medications. During this IPMH stay, Member #3 was verbally and physically aggressive requiring restraint and expressed anger due to DCBS not finding a new family. The plan was to transfer back to the PRTF. An MCO email indicated the member needed a new placement situation, obtaining updated information from DCBS, and sending out referrals. There was a gap in the MCO documentation for 9 days during this period of the IPMH/PTRF stay and authorization information was not available. MCO notes resumed when the member was admitted to the PRTF. DCBS notes indicated that an adoptive family was being sought and the member would have outings with the DCBS worker when ready. DCBS described an issue with facility #2 regarding ordering/administering seizure medications and that the seizure activity was atypical and might have been contributing to the members behavioral issues. Member #3 displayed aggression, self-injuring behaviors, AWOL activity, sexual acting out, suicidal and homicidal ideation, and property destruction. There was no update available on the discharge plan. The MCO noted concerns about the limited number of individual therapy sessions occurring and the facility's lack of attempts to contact DCBS. DCBS conducted pre-placement consultation for a prospective foster/adoptive family. Member #3 continued to have periods of aggression and inappropriate behaviors but showed some improvement in mood, affect, insight, judgment with improved behavior and motivation due to attempts to find a family placement. Phone calls and visits by the prospective family continued. Facility #2 noted considerably better behavior after family visits, but has episodes of aggression and inappropriate behaviors at times.

Member #3 expressed concerns regarding foster/adoptive family's plan to move out of state. Member #3 with continued behavioral issues/AWOL, and it was stated this might be due to missing the foster/adoptive family and their living out of state. Member #3 expressed the desire to be discharged to the adoptive family. There was an extended wait for the adoption approval due to the inter-state process. On day # 153 the MCO sent the case to UM MD review. Continued stay was denied due to the member did not meet medical necessity criteria, clarification regarding discharge plan/foster family placement was needed, and limited progress despite extended treatment time. Two days later, Member #3 was emergently admitted to IPMH LOC at facility #2 due to suicidal ideation with plan. The member was transferred back to the PRTF after 2 days. Another UM MD referral was completed. Continued stay was denied due to the member did not meet medical necessity criteria, behaviors were chronic, the member had not made progress, there was no reasonable expectation of benefit from continued treatment, it was unclear if the discharge plan to OOS foster family was being pursued, the member remained at IP LOC due to discharge disposition/custodial issues only, with 2 days allowed for discharge planning. The MD Reviewer recommended transition to community-based level of care with intensive services. An expedited appeal was filed and the decision was upheld. There was a 1 day gap in the MCO documentation during this admission and authorization information not available. MCO notes resumed with an emergent IPMH admission post AWOL from PRTF. Member #3 displayed physical aggression, property destruction, and self-injuring. PRTF facility #2 declined to accept the member back. During this time, Member #3 reported not wanting to go to PRTF, instead, wanted to go home to adoptive family. The MCO noted that a Coordination of Care referral was made; however, there was no related documentation. The discharge plan continued to be OOS foster/adoptive family, once approved. DCBS requested an expedited approval for the adoption as the member's behaviors appeared to be related to delayed placement with the adoptive family. An MCO note indicated that since PRTF would not accept the member back, DCBS desired that the member to stay in IPMH LOC until the adoption approval process was completed and the member could be discharged to the adoptive family. There were notation(s) of MCO attempt(s) to contact DCBS regarding the discharge plan. On day #6, the case was sent for UM MD review. Continued stay was denied as of day #7 due to the member was doing well at the IPMH LOC with no acute symptoms and did not meet medical necessity criteria and a recommended discharge plan of step-down to PTRF and placement OOS, with 2 days allowed for discharge planning. An expedited appeal was filed and the decision was upheld. The facility indicated that an appeal would be filed for all days denied after final discharge. After the IPMH continued stay denial, there was a gap in the MCO documentation for 16 days. MCO notes resumed with review of a pre-certification request for PRTF admission at facility #2 due to physical aggression, manic behavior, and anxiety regarding discharge placement. The MCO noted the prior PRTF denial due to baseline status/maintained for placement only. The case was sent for UM MD review. The PRTF admission was denied due to the prior PRTF stay of 153 days with subsequent emergent IPMH admission. The MCO noted that the member did not meet medical necessity criteria as the behaviors were baseline and the member had reached

maximum benefit from treatment. The MD recommended treatment in a community setting with supports for patients with mental retardation and behavior issues. There were no further MCO notes after this, although there was a DCBS notation of a subsequent PRTF stay approval ~ 1 week later. Subsequent DCBS notes through 12/2014 stated that the member was in PRTF, was communicating with the adoptive family, and the approval for the adoption was still pending. The member had a one week visit at family's OOS home which was extended. The adoption was approved in 12/2014 and Member #3 was officially discharged from the PRTF.

DCBS notes included a note in 1/2014, prior to IPMH admission #1. There were no MCO notes prior to IPMH admission #1. MCO notes were initiated upon the first IPMH admission to facility #1. The MCO documentation included assessments from admitting facilities. There was no care plan. MCO notes were related solely to UR functions. There were 3 gaps in MCO documentation where authorization information was not available. There were no MCO notes after the pre-certification denial for the last PRTF admission. There was some evidence of coordination of care with DCBS. Regarding continuity of care, as described, there were gaps in documentation and no MCO notes after the final pre-certification denial for PRTF admission. There was some MCO participation in discharge planning; however, notably, MCO documentation was absent for the final PRTF admission through final discharge/permanent placement of the member with the adoptive family. The UM decisions were timely and appropriately documented. As described, the MCO (both RN reviewer and MD reviewer) identified a potential quality of care issue at one of the facilities and the MCO contacted the facility. The issue was not confirmed, so it appears it was corrected.

A noteworthy observation is that both the MCO and the DCBS documentation (and the included facility notes) suggested that the member was angry due to having been abandoned by biological family and had difficulty coping with that and being confined to a facility. The member expressed anger through aggressive verbal and physical behaviors, self injuring, sexual acting out, stealing, hoarding, and running away. This appeared to be complicated by a seizure disorder, ADHD, and mild MR. The member was eventually able to communicate this and communicated the desire to live with a family in a home with a yard and a dog. Also, the member's behavior was considerably better when there was positive news about placement with the adoptive family or when there were family visits and communications.

Case #4

Member #4 was a teen with diagnoses of ADHD; bipolar disorder; mild mental retardation/IQ 71; unspecified episodic mood disorder; other conduct disorder; other unknown and unspecified cause of morbidity and mortality; sexual offender; history of substance abuse; rule out post-traumatic stress disorder, and with a history of parental emotional abuse and sexual abuse by an adult (non-relative).

Member #4 had ~ 10 admissions during the review period at 5 facilities; one elopement with a brief stay at an emergency shelter for children (facility #1) for 2 days; one RTF admission (facility #2) for 40 days, one IPMH admission (facility #3) for 2 days; one RTF admission (facility #2) for 19 days, one IPMH

admission (facility #4) for 22 days; one RTF admission (facility #5) for 148 days; one elopement with a brief stay at an emergency shelter for children (facility #1) for 6 days; one RTF admission (facility #5) for 17 days; one elopement for 1 day; and one RTF admission (facility #5) for the remainder of 2014, 36 days.

Member #4 lived with a parent from birth until 13 years of age; with different relatives for 1 year; spent some time living with grandparent and ran away; was placed in a residential treatment setting for sexual offenders for 1 year; and was then transferred to another RTF after elopement. Member #4 had sibling(s) who lived with parent. DCBS was involved due to behaviors including verbal and physical aggression, inappropriate sexual behaviors, defiance, sneaking out of home, substance and alcohol abuse, truancy, and law enforcement involvement. Member #4 was a sexual offender on probation until age 18 with a history of charges for resisting arrest and contempt of court.

MCO documentation prior to the first RTF elopement incident included only authorizations for outpatient BH treatment and targeted BH case management. Notes from the targeted BH case management were not included. DCBS notes indicated that Member #4 was in treatment through DCBS referral and working toward family reunification. Upon elopement, DCBS met with Member #4 at the emergency shelter and the member was admitted to RTF admission at facility #2. The only MCO notes continued to be service authorizations. The member had suicidal ideation and uncontrollable behaviors during RTF admission (facility #2) and was admitted to IPMH (facility #3) for 2 days. The only MCO note was for IPMH authorization. The member was discharged to RTF (facility #2) but continued defiant behavior, verbally and physically aggressive behaviors requiring physical management, sexually inappropriate behaviors, and AWOL attempts, but participated in therapy, had positive phone calls with parent, maintained good grades in school and was able to make some progress with substance abuse treatment. Member #4 continued to express not wanting to be in RTF and desire to go home to parent, not grandparent. Member #4 had a second IPMH admission (facility #4) due to suicidal ideation, self-injuring, and unmanageable behaviors with estimated LOS of 18 days and plan to discharge back to RTF (facility #2). There was an MCO note regarding IPMH authorization and continued stay reviews and MCO notes regarding attempted contact with DCBS (2 times). The PRTF (facility #2) indicated that the member would not be accepted back. On day #3, there was an MCO referral for MD review. The MD reviewer completed a peer-to-peer discussion and continued stay was denied due to lack of medical necessity, with 2 days allowed for discharge planning and MD recommendation that needs could be met with OPMH treatment and appropriate placement. DCBS/MCO communications indicated that DCBS sought RTF placements statewide and all were rejected, except 1 with no response. Member #4 was being considered for RTF at facility #5, but there was a long waiting list. Conference call(s) to discuss placement were scheduled and call was held with DCBS, IPMH facility, and 2 other agencies (not MCO). Member continued stay at IPMH facility despite decertification/continued stay denial. The facility later

appealed the decision and the denial was upheld. On day #37, a DCBS note indicated that the member was accepted at RTF facility #5 but was on the wait list. Member #4 continued to express the desire to return to parent and had phone contact with parent. Parent was unable to visit. Member was reportedly fighting with peers and “cheeking” medications. The member was discharged to RTF facility #5. On day #4, an incident occurred where member stripped, physically attacked staff, made sexually inappropriate comments to staff, and indicated desire to AWOL to get high. The parent was invited to participate in therapy but did not respond and this indicated the viability of reunification was unknown. On day #20, the member was making progress with therapy and maintaining good grades with discharge goal of returning to parent. The member still had inappropriate sexual gestures, aggressive behavior, and struggles with drug cravings. During this RTF stay, Member #4 had ongoing issues with aggression, inappropriate sexual behavior, and self-harm, AWOL plots, drug cravings and required physical intervention, isolation, and seclusion but was making some progress in therapy with periods of improved behavior. As of day #146, the member was showing improvement, was off AWOL precautions, and parent was participating in some therapy, with a home visit being considered. On day #148, the member went AWOL for 6 days with a brief stay at the emergency shelter for children. Member #4 had confirmed drug use and sexual activity during this AWOL event. Member #4 was returned to RTF (facility #5). The member’s behaviors continued same as before and there was another incident of AWOL for 1 day on day #17 with the member returned to the RTF (facility #5). There was noted confirmed promiscuity and a positive test for cocaine. During this continued RTF stay, Member #4 had ongoing issues with defiance, verbal and physical aggression requiring physical intervention, restraint, isolation, and seclusion, and drug cravings. A new substance abuse treatment program was initiated. Member #4 inquired about plans for the future and was told that improved behavior was necessary in order to earn a home visit and transfer to an independent living (IL) cottage, though this would not occur soon. The discharge plan was a transfer to a step-down residential setting or foster care before being released home. The member had a court ordered commitment until age 18 due to unpredictable behavior and the parent’s instability. The member maintained contact with both parents, one regularly, the other sporadically; however, the parent was making limited efforts toward reunification. Member #4 was a high risk due to unpredictable behaviors, immaturity, use of body to get drugs and putting self in dangerous situations. As of the end of 2014, the member began making some progress in treatment, showed increased motivation, improved moods and behaviors, and had stronger performance in school. The member was in contact with parent and siblings via phone. There were some parent visits at the facility, but the parent continued to have minimal involvement in therapy. The discharge plan remained transfer to step-down program/pre-independent living followed by unification with family after court order commitment ended.

DCBS notes demonstrated that the member was followed from prior to January 2014 through December 2014, where the period of review ended. MCO notes for the beginning of review period were limited to

service authorizations. More substantive MCO notes were seen after the second IPMH admission and return to RTF, where there were IPMH authorizations, continued stay reviews, and notes regarding contact attempt(s) with DCBS. However, most of the MCO notes appeared to be related solely to UR functions. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no real evidence of coordination of care and services other than UM activities. Continuity of care activity was limited, as was participation in discharge planning. It is particularly notable that there were no MCO notes after continued stay at the RTF was denied, except a few emails among DCBS, the MCO, and “Bluegrass” after the last covered RTF day and notation of the IPMH appeal. This is despite the occurrence of a number of significant events during the subsequent timeframe. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Case #5

Member #5 was a teen with diagnoses of psychiatric disorder NOS; unspecified psychosis; other unknown and unspecified cause of morbidity and mortality. One of the member’s parents had a diagnosis of schizophrenia and the other had alcoholism.

Member #5 had 1 IPMH admission for 29 days during the period reviewed.

Member #5 was introduced to DCBS due a CPS incident related to risk of harm, neglect, physical assault/injury ~ 1 month prior to IPMH admission. DCBS met Member #5 at an adult friend’s home (specific relationship not stated), where the member had been staying for 5-6 days. Member #5 stated that he liked to stay at this friend’s home due to it was a quieter neighborhood and this adult never tries to harm member. The adult reported that the member did not eat much. Member #5 claimed he went to the hospital because his parent hit him in the stomach. This could not be confirmed by the adult friend. The adult reported that he took the member on an outing with parents’ permission and the member complained of a stomach ache. An interview with 1 parent revealed that the parent was worried about complaints of stomach ache, took member to ER, and the doctor gave them medication. This parent reported that they do not hit the member for discipline and they were worried about “nerves”. The other parent refused to be interviewed at that time. A later interview with parent #2 confirmed the information provided by parent #1. Parent #2 also reported that Member #5 has trouble with “nerves” and was seen at clinic, got medication and is better. The clinic confirmed seeing the member. The clinic doctor stated that parents were asked to take Member #5 for therapy and was told by parent #2 that the member already saw a therapist. A second CPS incident, ~ 1 month after the first, related to medical neglect. The DCBS worker was called to Member #5’s home where there was an ambulance and police present. Member #5 had gone to the Housing Authority and called the police to report that parent #1 was poisoning him/her, made a storm attack him/her, and cursed him/her. Parent #2 was found yelling at the member. The police intervened. Member #5 was described as slumped over,

unbalanced, pale, emotionless and staring into space. Member #5 was taken by EMS and PD to the ER. In the ER, Member #5 was in a daze, would not speak and would not move. The member continued to report parent was poisoning him/her and threatened to kill him/her and that he/she was getting weaker and dumber and losing memory due to poisoning by parent. Member #5 was able to recall all the medications given by parent. Again, the DCBS worker was called by police to member's home due to CPS incident related to medical neglect. The police reported that the member's MH status was more severe. Member #5 appeared lethargic and meek and had written 2 letters about threats to safety and fears. The parents were reportedly not cognizant of the seriousness of the child's condition. Member #5 was taken to the ER and an IPMH mobile assessment was performed. Member #5 met the criteria for IPMH admission. The DCBS worker visited the parents to request consent for IPMH admission and was denied entry. Parent #2 refused and was told by the worker that the State would take custody if necessary. The child was felt to be at risk of not having MH needs addressed despite meeting criteria for IPMH admission. An emergency custody order was requested and granted with a Temporary Removal Hearing scheduled for 4 days later. Parent #2 refused to allow the police to take the member, became aggressive, and was arrested. Member #5 was transported to the IPMH facility and admitted. The first MCO note occurs on this date. The MCO note consists of an initial authorization for IPMH admission due to suicidal ideation, command auditory hallucinations, visual hallucinations, the belief that parents are poisoning him/her and refusal to eat, preoccupation with religion and belief that he/she was hit by lightning. A visit by DCBS worker on day #1 revealed that the member was more alert, eating and talking but had not bathed or changed clothes and did not want to see parents. The Temporary Removal Hearing was held and the member remained in the custody of the State. An MCO review on day #4 authorized continued stay. An MCO review day #5 noted a call that was made and message left for DCBS and there was an MCO MD recommendation for further treatment at a residential setting once stabilized. On day #7, continued stay was authorized. A DCBS visit on day #12 revealed that the member still refused to shower or use the toilet due to the belief that there were cameras in the bathroom. The treatment plan was to ensure that the member began to eat, drink, and take meds correctly prior to discharge. An MCO continued stay review on day #12 resulted in referral for MD review. Continued stay was denied due to limited progress, refusing medications with no plan for court intervention, and not posing harm to self or others, with 2 days allowed for discharge planning. An expedited appeal resulted in the decision being overturned due to acute continued psychosis and paranoia, not eating, need for acute stabilization at IPMH level of care and plan for facility MD to obtain outpatient commitment to take medications. The discharge plan was for therapeutic foster care with DCBS as guardian. A DCBS note on day #13 revealed that Member #5 was still not eating or drinking and medications were still being adjusted. MCO UR was done on day #13 with continued stay authorized. The MCO requested that facility consider "MH EPSDT". MCO UR was done on day #14 and indicated that Member #5 was still paranoid, still refused to shower due to the belief of a camera in the bathroom, was not happy on the unit (low functioning), but was more compliant with meds and the discharge plan was "per DCBS". This

was the final MCO note. DCBS notes for days #19 & #21 indicated that Member #5 began to eat, drink, sleep better, and shower and wanted to see his parents and family therapy would begin. On day #29, Member #5 was placed in a Private Child Care/Therapeutic Foster Care (PCC/TFC) home. DCBS notes indicated that Member #5 continued in this home for the remainder of 2014, continued receiving therapy, attended regular school and was passing all classes, participated in sports, had supervised visitation with parents, and was getting along well with everyone in the foster home.

DCBS notes demonstrated that the member was followed from prior to the first admission through the end of 12/2014. MCO notes were initiated with the authorization for IPMH admission. Subsequent MCO notes were related solely to utilization review functions and there was a notation of communication with DCBS. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. There was no evidence of coordination of care/continuity of care other than UM activities. The final MCO note occurred prior to discharge, on day #14 of the IPMH admission. There was some evidence that the MCO followed discharge planning; however the MCO notes ended prior to final discharge arrangements being made. There was no documentation by the MCO after the member's discharge to the foster home. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Overall Findings

Overall findings that can be generalized to most or all of the cases include the following:

- UM processes were appropriately followed.
- UM decisions were supported with appropriate rationale.
- UM decisions and communication were timely.
- Although the UM decisions were well-supported, the decisions appeared to have been made in a vacuum, without acknowledgement that there might not have been an alternative placement available for the member.
- Facility quality of care issues were identified, confirmed, and addressed by the MCO.
- There was lack of care management/care coordination, with no MCO assessments or care plans (or copies of the DCBS assessments and care plans) and members were not always followed or monitored on a routine/ongoing basis.
- There was no evidence of linkages to internal MCO services or external resources by the MCO.
- The MCO care management documentation was primarily related to UM activities.
- Although DCBS had primary responsibility for care management, there was minimal evidence of attempts to coordinate with DCBS, obtain information on the members' status and, in most cases, limited participation in discharge planning or none.
- There was lack of continuity of care. Specifically, the MCO did not ensure post-discharge follow-up care or continue to monitor the member/attempt to obtain updates on the member's status after UM issues were resolved, the continued stay was denied, and/or the member was discharged.

Findings related to specific cases include the following:

- A high-risk member was discharged to TFC and the MCO did not continue to monitor the member's status in that setting.
- A high-risk member was denied continued stay but remained at the IPMH facility. There was no evidence that the MCO continued to monitor the member's status during the remainder of the IPMH stay and after the discharge to a RTF, despite several significant events during the 8-9 month period.
- MCO documentation for a high-risk member had multiple gaps of between 3-16 days and the MCO documentation ended after continued stay was denied, despite the fact that the member was waiting placement for an out-of-state adoption.
- During the period of review, the MCO documented involvement for only 1 of 3 BH admissions for a high-risk member. For the 1st admission, the member was enrolled in the MCO as of the 6th month of this 16-month admission. For the 2nd and 3rd admissions, the member was enrolled in the MCO for the entire period. There was MCO documentation during the 2nd admission; however, the MCO documentation ended after a denial of continued stay. There was no evidence of coordination of care prior to or after discharge from admission #2, except an authorization for OPMH services.
- There was no evidence of MCO involvement post-discharge for a high-risk member, except authorization(s) for OPMH services.

Recommendations

Recommendations to DMS include:

- Provide the review findings to the MCO.
- Allow the MCO to respond to the overall findings as well as specific case findings.
- Provide the case review findings summary report to DCBS for comments and suggestions.
- If DMS concerns warrant, request Corrective Action Plan (CAP) from the MCO.
- Review a small sample of cases of other MCOs' DCBS members with BH admissions to identify if there are common issues and/or best practices.

Recommendations to the MCO include:

- Implement improvements to the process for case management for DCBS members with BH conditions and frequent admissions and those who are hard to place and maintain active involvement in these cases.
- Upon notification of a BH admission, immediately begin coordinating care with the facility and DCBS.
- Analyze claims data to identify DCBS members and other pediatric members with BH conditions and conduct outreach, assessments, and initiate care management activities where needed.

- Ensure continuity of care for DCBS members with BH admissions by actively participating in discharge planning, ensuring post-discharge follow-up care is provided, and continuing to monitor the member's status post-discharge.
- Despite a denial of continued stay, continue to coordinate with DCBS regarding the member's status and needs.



09/18/15

Via FTP Upload

Chuck Merlino, MBA, CHCA
Director, Managed Care
IPRO
1979 Marcus Avenue
Lake Success, NY 11042

Re: Coventry Case File Review

Dear Mr. Merlino:

Thank you for very much for the opportunity to review the IPro on the Review of CoventryCares and DCBS Children with Inpatient Behavioral Health Decertification audit findings and provide our responses back related to the findings on page 14 as well as the recommendations.

In addition, please accept our response and acknowledgement of the recommendations to improve our performance and we request your acceptance of the following summary for the five (5) cases identified below:

Case #1

Member #1 was a teen with diagnoses of history of neglect and sexual abuse; sexual disorder/deviation; other episodic mood disorder; impulse control disorder; hyperkinesia with developmental delay; mental retardation/IQ 52-55; cerebral palsy; asthma; who was born premature and addicted to cocaine.

Member #1 had 2 admissions during the period reviewed; one psychiatric residential treatment facility (PRTF) sexual offender treatment program (SOTP) admission for 152 days and one out-of-state (OOS) PRTF/inpatient mental health (IPMH) admission for 61 days.

Member #1 was living with adoptive family and was followed by DCBS due to inadequate supervision and hoarding (by adoptive family). Member #1 had incidents of sexual offending against adoptive siblings who were then placed in temporary foster care. Member #1 was removed to PRTF #1, with an estimated length of stay (LOS) of 3-6 months. During PRTF #1 stay, member had inappropriate sexual behaviors, oppositional-defiant behaviors, aggressive and destructive behaviors. Continued stay was denied on the 56th day due to limited progress in therapy with only temporary improvement, with 2 days allowed for discharge planning. An expedited appeal upheld the decision. A subsequent conference call with the MCO, facility #1, and DCBS resulted in the denial being overturned. There was no documentation in the MCO or

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DCBS records regarding the specifics of this call. The following day, Member #1 committed a sexual offense against a peer. Member #1 continued treatment at PRTF #1 due to lack of appropriate placement options, possible out of state placement, and the need for very close supervision. On the 111th day, continued stay was again denied and the MD reviewer recommended that the member needed a program for low IQ, specifically. An expedited appeal upheld the decision.

Member #1 remained at the facility pending possible placement at an OOS facility. On the 151st day, the admissions department at the OOS facility #2 was contacted. The member was transferred to the OOS facility #2 on the 154th day with an estimated LOS of 30 days and a plan to discharge to adoptive parent. There was some question whether the adoptive parent fully understood the risk of having member in the home and possessed the ability to adequately supervise the member. During this admission, there was a confirmed quality of care issue identified by the MCO. Facility #2 submitted a corrective action plan. On the 61st day, Member #1 was discharged to the adoptive parent with home services and outpatient behavioral health (BH) treatment, including individual and family therapy. Member #1's siblings were living outside the adoptive home but there were suspected incidents of sexual offending against 1 sibling and a peer at school.

DCBS notes demonstrated that the member was followed from prior to the first admission through discharge home with outpatient therapy until 12/2014. MCO notes were initiated at the time of the first admission through second admission but were related solely to utilization review (UR) functions. There was one MCO note after the second discharge, but it was an authorization for outpatient BH therapy only. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no evidence of coordination of care/continuity of care other than utilization management (UM) activities. There was no documentation by the MCO after the member's discharge to the adoptive home, except the outpatient authorization. There was evidence of some participation in discharge planning. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Member #1 remained at the facility pending possible placement at an OOS facility. On the 151st day, the admissions department at the OOS facility #2 was contacted. The member was transferred to the OOS facility #2 on the 154th day with an estimated LOS of 30 days and a plan to discharge to adoptive parent. There was some question whether the adoptive parent fully understood the risk of having member in the home and possessed the ability to adequately supervise the member. During this admission, there was a confirmed quality of care issue identified by the MCO. Facility #2 submitted a corrective action plan. On the 61st day, Member #1 was discharged to the adoptive parent with home services and outpatient behavioral health (BH) treatment, including individual and family therapy. Member #1's siblings were living outside the adoptive home but there were suspected incidents of sexual offending against 1 sibling and a peer at school.

DCBS notes demonstrated that the member was followed from prior to the first admission through discharge home with outpatient therapy until 12/2014. MCO notes were initiated at the time of the first admission through second admission but were related solely to utilization

review (UR) functions. There was one MCO note after the second discharge, but it was an authorization for outpatient BH therapy only. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no evidence of coordination of care/continuity of care other than utilization management (UM) activities. There was no documentation by the MCO after the member's discharge to the adoptive home, except the outpatient authorization. There was evidence of some participation in discharge planning. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case 1: iPro recommendation:

Implement improvements to the process for case management for DCBS members with BH conditions and frequent admissions and those who are hard to place and maintain active involvement in these cases.

MCO response:

Both admissions were long term residential treatment, which does not qualify for HEDIS follow up measure so there, is not an automatic trigger for CM outreach. CoventryCares of Kentucky will enhance their current policy and processes. CoventryCares is in the process of creating a robust integrated care management program. Training is ongoing and a gap analysis is ongoing to improve the coordination of care and communications with the facilities and DCBS. CoventryCares of KY has a policy CM-011, "Case Management for Members in Foster Care and Members who are receiving Adoption Services" and upon review, it is the belief of the MCO that the enhancements will strengthen the integrated care management program while offering more coordination of care to the DCBS population.

Case #2

Member #2 was a teen with diagnoses of sexual offender; unspecified psychosexual disorder; history of possible sexual abuse; impulse control disorder; asthma; and other ill-defined and unknown causes of morbidity and mortality. Member #2 had 3 admissions during the review period; one residential treatment center (RTC) SOTP for > 1 year (~ 16 months), one RTC SOTP for 44 days, and one residential children's center (RCC) with SO treatment for ~ 71 days. The first RTC SOTP admission began prior to enrollment with the MCO; but the member was enrolled in the MCO for 304 days through discharge from this facility. There were only DCBS notes for this portion of the review period.

Member #2 was born to a teen mom, had never met father, raised by grandparents, and had three siblings. Member #2 lived with mother, her husband, younger half-sibling and maternal grandparents. During 2012, Member #2 and sibling were placed in State custody due to domestic violence. Foster family raised concerns regarding sexual offending (SO). There was law enforcement/legal involvement. At some point, Member #2 lived with Aunt who denied any SO

events. Admitted to facility #1 and failed treatment there with incident(s) of SO against peer(s). Member #2 was transferred from facility #1 to facility #2. Member #2 admitted to RTC SOTP #2 with estimated LOS 9 months and discharge plan of Coventry-DCBS-BH-DeCert-Case_Review_Summary_Report_FINAL7 23 15 Page 4 of 14

DCBS placement, Aunt's custody, or with family in Florida. Member made some progress at RTC SOTP #2, but showed disobedience/defiance, inappropriate behaviors, and hoarding. A quality of care issue was confirmed by the MCO at facility #2, with no response from the facility. Continued RTC SOTP #2 stay was denied on day #42 due to lack of medical necessity, not reasonably expected to improve under treatment plan and documentation does not support program protocol, with 2 days for discharge planning. MD reviewer recommended group home setting, outpatient treatment for SO, and family therapy. An expedited appeal was filed, supported by DCBS and DPP, with denial upheld. As a result of the continued stay denial, Member #2 was transferred to RCC with SO treatment on day # 55, with a discharge plan to return to parent or therapeutic foster home. On day #153, the discharge goal was changed to adoption. DCBS notes ended as of 12/2014, with member progressing through the SO program and attending public school and with a discharge plan to either return to parent, foster care, or adoption.

DCBS notes demonstrated that the member was followed from RTC SOTP #1 through end of review period. There were no MCO notes provided for the first admission, although the member was enrolled in the MCO for the majority of that admission. MCO notes were initiated at the time of transfer from RTC SOTP #1 to #2. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. MCO notes were related solely to UR functions. There were no MCO notes after transfer from RTC SOTP #2 to RCC. During the RCC admission, MCO documentation included only an authorization for outpatient BH therapy. There was no evidence of coordination of care/continuity of care other than UM and only for the period during RTC SOTP #2 stay. The member was followed by the MCO only during RTC SOTP #2 stay. Transfer to RCC was the result of denial of continued stay at RTC SOTP #2. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case 2: iPro recommendation:

Upon notification of a BH admission, immediately begin coordinating care with the facility and DCBS.

MCO response:

The admission was for residential treatment, which does not qualify for a HEDIS follow up measure, so it does not automatically trigger CM outreach. CoventryCares of Kentucky developed a daily census report that includes a specific tab for the foster care population. This allows immediate outreach to the facility as well as an agenda item at the DCBS meetings. The

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utilization of this tool has recently become part of the case management referral process. The integration of BH into the physical health CM department is a relatively new process and iPro's recommendations for improvements will only strengthen our program.

Case #3

Member #3 was a teen with diagnoses of bipolar disorder; mild mental retardation/IQ 61; ADHD with hyperactivity; unspecified hyperkinetic syndrome; unspecified disturbance of conduct; anxiety; other specified episodic mood disorder; other unknown and unspecified cause of morbidity and mortality; seizure disorder; rule out medication side effects and akathisia; constipation; and seasonal allergies.

Member #3 had 4 admissions with periods of elopement/away without leave (AWOL) in 2 facilities during the review period: one IPMH admission at facility #1 for 12 days; one admission at facility #2 at both IPMH and PTRF levels of care for 23 days, one admission at facility #2 at both PTRF and IPMH levels of care for 187 days (denied after day #170); and one admission at facility #2 at the PTRF level of care for 54 days (denied in its entirety). Coventry-DCBS-BH-DeCert-Case_Review_Summary_Report_FINAL7 23 15 Page 5 of 14

Member #3 was residing at a children's home as a result of being removed from parents' custody due to physical abuse and neglect and relinquishing parental rights in 2009. Siblings remained with one of the parents. Member #3 had been in foster care but family could not meet his/her mental health needs. Member #3 had a prior history of 2 IPMH admissions in 2012. Member #3 was said to be compliant with medications. Member #3 was admitted emergently to IPMH for severe aggression and self harm. MCO note at this time stated "Coordination of Care referral: No." Upon admission, the children's home gave notice that they would not accept the member back upon discharge. MCO note stated that PRTF placement should be considered on discharge and possible placement issues. During this stay, the member was noted to be physically aggressive to staff, peer(s), and self, had destructive behaviors and manic behavior and speech, and continuously described wanting a family. Member #3 transferred to PRTF at facility #2 with an estimated LOS of 6 months and discharge plan "per DCBS". During the stay at facility #2, the member displayed verbal and physical aggression toward staff and peers, destructive behaviors, sexual acting out and was transferred from PRTF to IPMH level of care at facility #2 for 8 days due to suicidal ideation/gesture, homicidal ideation with no plan, multiple elopement incidents, criminal behavior with law enforcement involvement, with a plan to transfer back to PTRF level of care. During the IPMH period, the member had manic behavior and reported visual and auditory hallucinations. The MCO noted telephone outreach DCBS at this time. There was a gap in the MCO documentation for 3 days during this IPMH admission and authorization information was not available. MCO notes resumed with the IPMH admission to facility #2. The notes indicated that the member was AWOL from PTRF and displayed physical aggression toward staff requiring injected medications. During this IPMH stay, Member #3 was verbally and physically aggressive requiring restraint and expressed anger due to DCBS not finding a new family. The plan was to transfer back to the PRTF. An MCO email indicated the member needed a new placement situation, obtaining updated information from DCBS, and sending out referrals. There was a gap in the MCO

documentation for 9 days during this period of the IPMH/PTRF stay and authorization information was not available. MCO notes resumed when the member was admitted to the PTRF. DCBS notes indicated that an adoptive family was being sought and the member would have outings with the DCBS worker when ready. DCBS described an issue with facility #2 regarding ordering/administering seizure medications and that the seizure activity was atypical and might have been contributing to the members behavioral issues. Member #3 displayed aggression, self-injuring behaviors, AWOL activity, sexual acting out, suicidal and homicidal ideation, and property destruction. There was no update available on the discharge plan. The MCO noted concerns about the limited number of individual therapy sessions occurring and the facility's lack of attempts to contact DCBS. DCBS conducted pre-placement consultation for a prospective foster/adoptive family. Member #3 continued to have periods of aggression and inappropriate behaviors but showed some improvement in mood, affect, insight, judgment with improved behavior and motivation due to attempts to find a family placement. Phone calls and visits by the prospective family continued. Facility #2 noted considerably better behavior after family visits, but has episodes of aggression and inappropriate behaviors at times.

Member #3 expressed concerns regarding foster/adoptive family's plan to move out of state. Member #3 with continued behavioral issues/AWOL, and it was stated this might be due to missing the foster/adoptive family and their living out of state. Member #3 expressed the desire to be discharged to the adoptive family. There was an extended wait for the adoption approval due to the inter-state process. On day # 153 the MCO sent the case to UM MD review. Continued stay was denied due to the member did not meet medical necessity criteria, clarification regarding discharge plan/foster family placement was needed, and limited progress despite extended treatment time. Two days later, Member #3 was emergently admitted to IPMH LOC at facility #2 due to suicidal ideation with plan. The member was transferred back to the PTRF after 2 days. Another UM MD referral was completed. Continued stay was denied due to the member did not meet medical necessity criteria, behaviors were chronic, the member had not made progress, there was no reasonable expectation of benefit from continued treatment, it was unclear if the discharge plan to OOS foster family was being pursued, the member remained at IP LOC due to discharge disposition/custodial issues only, with 2 days allowed for discharge planning. The MD Reviewer recommended transition to community-based level of care with intensive services. An expedited appeal was filed and the decision was upheld. There was a 1 day gap in the MCO documentation during this admission and authorization information not available. MCO notes resumed with an emergent IPMH admission post AWOL from PTRF. Member #3 displayed physical aggression, property destruction, and self-injuring. PTRF facility #2 declined to accept the member back. During this time, Member #3 reported not wanting to go to PTRF, instead, wanted to go home to adoptive family. The MCO noted that a Coordination of Care referral was made; however, there was no related documentation. The discharge plan continued to be OOS foster/adoptive family, once approved. DCBS requested an expedited approval for the adoption as the member's behaviors appeared to be related to delayed placement with the adoptive family. An MCO note indicated that since PTRF would not accept the member back, DCBS desired that the member to stay in IPMH LOC until the adoption approval process was completed and the member could be

discharged to the adoptive family. There were notation(s) of MCO attempt(s) to contact DCBS regarding the discharge plan. On day #6, the case was sent for UM MD review. Continued stay was denied as of day #7 due to the member was doing well at the IPMH LOC with no acute symptoms and did not meet medical necessity criteria and a recommended discharge plan of step-down to PTRF and placement OOS, with 2 days allowed for discharge planning. An expedited appeal was filed and the decision was upheld. The facility indicated that an appeal would be filed for all days denied after final discharge. After the IPMH continued stay denial, there was a gap in the MCO documentation for 16 days. MCO notes resumed with review of a pre-certification request for PTRF admission at facility #2 due to physical aggression, manic behavior, and anxiety regarding discharge placement. The MCO noted the prior PTRF denial due to baseline status/maintained for placement only. The case was sent for UM MD review. The PTRF admission was denied due to the prior PTRF stay of 153 days with subsequent emergent IPMH admission. The MCO noted that the member did not meet medical necessity criteria as the behaviors were baseline and the member had reached maximum benefit from treatment. The MD recommended treatment in a community setting with supports for patients with mental retardation and behavior issues. There were no further MCO notes after this, although there was a DCBS notation of a subsequent PTRF stay approval ~ 1 week later. Subsequent DCBS notes through 12/2014 stated that the member was in PTRF, was communicating with the adoptive family, and the approval for the adoption was still pending. The member had a one week visit at family's OOS home which was extended. The adoption was approved in 12/2014 and Member #3 was officially discharged from the PTRF.

DCBS notes included a note in 1/2014, prior to IPMH admission #1. There were no MCO notes prior to IPMH admission #1. MCO notes were initiated upon the first IPMH admission to facility #1. The MCO documentation included assessments from admitting facilities. There was no care plan. MCO notes were related solely to UR functions. There were 3 gaps in MCO documentation where authorization information was not available. There were no MCO notes after the pre-certification denial for the last PTRF admission. There was some evidence of coordination of care with DCBS. Regarding continuity of care, as described, there were gaps in documentation and no MCO notes after the final pre-certification denial for PTRF admission. There was some MCO participation in discharge planning; however, notably, MCO documentation was absent for the final PTRF admission through final discharge/permanent placement of the member with the adoptive family. The UM decisions were timely and appropriately documented. As described, the MCO (both RN reviewer and MD reviewer) identified a potential quality of care issue at one of the facilities and the MCO contacted the facility. The issue was not confirmed, so it appears it was corrected.

A noteworthy observation is that both the MCO and the DCBS documentation (and the included facility notes) suggested that the member was angry due to having been abandoned by biological family and had difficulty coping with that and being confined to a facility. The member expressed anger through aggressive verbal and physical behaviors, self injuring, sexual acting out, stealing, hoarding, and running away. This appeared to be complicated by a seizure disorder, ADHD, and mild MR. The member was eventually able to communicate this and communicated the desire to live with a family in a home with a yard and a dog. Also, the

member's behavior was considerably better when there was positive news about placement with the adoptive family or when there were family visits and communications.

Case 3: iPro recommendation:

Analyze claims data to identify DCBS members and other pediatric members with BH conditions and conduct outreach, assessments, and initiate care management activities where needed.

MCO response:

Multiple inpatient admits to extended care and then to residential treatment and back to inpatient care and each was HEDIS exclusion upon discharge. However, multiple documents related to Susan's communication with DCBS were submitted. CoventryCares of Kentucky does incorporate data analysis into the identification process of our members who may be candidates for case management. Claims information related to all Foster Care members is shared with DCBS in monthly meetings at the state. Policy CM-017, "Case Management of Persons with Special Needs" states identification includes claim data. BH prior authorization process and their subsequent referrals are part of the integration of BH and PH in the CM department. iPro's recommendations provide opportunity for the case management department to enhance their existing process.

Case #4

Member #4 was a teen with diagnoses of ADHD; bipolar disorder; mild mental retardation/IQ 71; unspecified episodic mood disorder; other conduct disorder; other unknown and unspecified cause of morbidity and mortality; sexual offender; history of substance abuse; rule out post-traumatic stress disorder, and with a history of parental emotional abuse and sexual abuse by an adult (non-relative).

Member #4 had ~ 10 admissions during the review period at 5 facilities; one elopement with a brief stay at an emergency shelter for children (facility #1) for 2 days; one RTF admission (facility #2) for 40 days, one IPMH admission (facility #3) for 2 days; one RTF admission (facility #2) for 19 days, one IPMH admission (facility #4) for 22 days; one RTF admission (facility #5) for 148 days; one elopement with a brief stay at an emergency shelter for children (facility #1) for 6 days; one RTF admission (facility #5) for 17 days; one elopement for 1 day; and one RTF admission (facility #5) for the remainder of 2014, 36 days.

Member #4 lived with a parent from birth until 13 years of age; with different relatives for 1 year; spent some time living with grandparent and ran away; was placed in a residential treatment setting for sexual offenders for 1 year; and was then transferred to another RTF after elopement. Member #4 had sibling(s) who lived with parent. DCBS was involved due to behaviors including verbal and physical aggression, inappropriate sexual behaviors, defiance,

sneaking out of home, substance and alcohol abuse, truancy, and law enforcement involvement. Member #4 was a sexual offender on probation until age 18 with a history of charges for resisting arrest and contempt of court.

MCO documentation prior to the first RTF elopement incident included only authorizations for outpatient BH treatment and targeted BH case management. Notes from the targeted BH case management were not included. DCBS notes indicated that Member #4 was in treatment through DCBS referral and working toward family reunification. Upon elopement, DCBS met with Member #4 at the emergency shelter and the member was admitted to RTF admission at facility #2. The only MCO notes continued to be service authorizations. The member had suicidal ideation and uncontrollable behaviors during RTF admission (facility #2) and was admitted to IPMH (facility #3) for 2 days. The only MCO note was for IPMH authorization. The member was discharged to RTF (facility #2) but continued defiant behavior, verbally and physically aggressive behaviors requiring physical management, sexually inappropriate behaviors, and AWOL attempts, but participated in therapy, had positive phone calls with parent, maintained good grades in school and was able to make some progress with substance abuse treatment. Member #4 continued to express not wanting to be in RTF and desire to go home to parent, not grandparent. Member #4 had a second IPMH admission (facility #4) due to suicidal ideation, self-injuring, and unmanageable behaviors with estimated LOS of 18 days and plan to discharge back to RTF (facility #2). There was an MCO note regarding IPMH authorization and continued stay reviews and MCO notes regarding attempted contact with DCBS (2 times). The PRTF (facility #2) indicated that the member would not be accepted back. On day #3, there was an MCO referral for MD review. The MD reviewer completed a peer-to-peer discussion and continued stay was denied due to lack of medical necessity, with 2 days allowed for discharge planning and MD recommendation that needs could be met with OPMH treatment and appropriate placement. DCBS/MCO communications indicated that DCBS sought RTF placements statewide and all were rejected, except 1 with no response. Member #4 was being considered for RTF at facility #5, but there was a long waiting list. Conference call(s) to discuss placement were scheduled and call was held with DCBS, IPMH facility, and 2 other agencies (not MCO). Member continued stay at IPMH facility despite decertification/continued stay denial. The facility later appealed the decision and the denial was upheld. On day #37, a DCBS note indicated that the member was accepted at RTF facility #5 but was on the wait list. Member #4 continued to express the desire to return to parent and had phone contact with parent. Parent was unable to visit. Member was reportedly fighting with peers and "cheeking" medications. The member was discharged to RTF facility #5. On day #4, an incident occurred where member stripped, physically attacked staff, made sexually inappropriate comments to staff, and indicated desire to AWOL to get high. The parent was invited to participate in therapy but did not respond and this indicated the viability of reunification was unknown. On day #20, the member was making progress with therapy and maintaining good grades with discharge goal of returning to parent. The member still had inappropriate sexual gestures, aggressive behavior, and struggles with drug cravings. During this RTF stay, Member #4 had ongoing issues with aggression, inappropriate sexual behavior, and self-harm, AWOL plots, drug cravings and required physical intervention, isolation, and seclusion but was making some progress in

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therapy with periods of improved behavior. As of day #146, the member was showing improvement, was off AWOL precautions, and parent was participating in some therapy, with a home visit being considered. On day #148, the member went AWOL for 6 days with a brief stay at the emergency shelter for children. Member #4 had confirmed drug use and sexual activity during this AWOL event. Member #4 was returned to RTF (facility #5). The member's behaviors continued same as before and there was another incident of AWOL for 1 day on day #17 with the member returned to the RTF (facility #5). There was noted confirmed promiscuity and a positive test for cocaine. During this continued RTF stay, Member #4 had ongoing issues with defiance, verbal and physical aggression requiring physical intervention, restraint, isolation, and seclusion, and drug cravings. A new substance abuse treatment program was initiated. Member #4 inquired about plans for the future and was told that improved behavior was necessary in order to earn a home visit and transfer to an independent living (IL) cottage, though this would not occur soon. The discharge plan was a transfer to a step-down residential setting or foster care before being released home. The member had a court ordered commitment until age 18 due to unpredictable behavior and the parent's instability. The member maintained contact with both parents, one regularly, the other sporadically; however, the parent was making limited efforts toward reunification. Member #4 was a high risk due to unpredictable behaviors, immaturity, use of body to get drugs and putting self in dangerous situations. As of the end of 2014, the member began making some progress in treatment, showed increased motivation, improved moods and behaviors, and had stronger performance in school. The member was in contact with parent and siblings via phone. There were some parent visits at the facility, but the parent continued to have minimal involvement in therapy. The discharge plan remained transfer to step-down program/pre-independent living followed by unification with family after court order commitment ended. DCBS notes demonstrated that the member was followed from prior to January 2014 through December 2014, where the period of review ended. MCO notes for the beginning of review period were limited to service authorizations. More substantive MCO notes were seen after the second IPMH admission and return to RTF, where there were IPMH authorizations, continued stay reviews, and notes regarding contact attempt(s) with DCBS. However, most of the MCO notes appeared to be related solely to UR functions. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no real evidence of coordination of care and services other than UM activities. Continuity of care activity was limited, as was participation in discharge planning. It is particularly notable that there were no MCO notes after continued stay at the RTF was denied, except a few emails among DCBS, the MCO, and "Bluegrass" after the last covered RTF day and notation of the IPMH appeal. This is despite the occurrence of a number of significant events during the subsequent timeframe. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Case 4: iPro recommendation:

Ensure continuity of care for DCBS members with BH admissions by actively participating in discharge planning, ensuring post-discharge follow-up care is provided, and continuing to monitor the member's status post-discharge.

MCO response:

Only two of the ten documented admissions were eligible for Medicaid MCO reimbursement, the other placements were via DCBS and each admission was HEDIS exclusion upon discharge, which did not trigger an automatic CM outreach. Case management participates in weekly meetings with all four (4) of the inpatient psychiatric facilities to discuss members who are or will be discharging. Communication is ongoing until discharge or placement and then transition of care to the MCO is facilitated. BH discharge meetings were recently transitioned to the physical health case management team as part of the integration process. CoventryCares of Kentucky recognizes the need and appreciates iPro's recommendation.

Case #5

Member #5 was a teen with diagnoses of psychiatric disorder NOS; unspecified psychosis; other unknown and unspecified cause of morbidity and mortality. One of the member's parents had a diagnosis of schizophrenia and the other had alcoholism.

Member #5 had 1 IPMH admission for 29 days during the period reviewed.

Member #5 had 1 IPMH admission for 29 days during the period reviewed.

Member #5 was introduced to DCBS due a CPS incident related to risk of harm, neglect, physical assault/injury ~ 1 month prior to IPMH admission. DCBS met Member #5 at an adult friend's home (specific relationship not stated), where the member had been staying for 5-6 days.

Member #5 stated that he liked to stay at this friend's home due to it was a quieter neighborhood and this adult never tries to harm member. The adult reported that the member did not eat much. Member #5 claimed he went to the hospital because his parent hit him in the stomach. This could not be confirmed by the adult friend. The adult reported that he took the member on an outing with parents' permission and the member complained of a stomach ache. An interview with 1 parent revealed that the parent was worried about complaints of stomach ache, took member to ER, and the doctor gave them medication. This parent reported that they do not hit the member for discipline and they were worried about "nerves". The other parent refused to be interviewed at that time. A later interview with parent #2 confirmed the information provided by parent #1. Parent #2 also reported that Member #5 has trouble with "nerves" and was seen at clinic, got medication and is better. The clinic confirmed seeing the member. The clinic doctor stated that parents were asked to take Member #5 for therapy and was told by parent #2 that the member already saw a therapist. A second CPS incident, ~ 1 month after the first, related to medical neglect. The DCBS worker was called to Member #5's home where there was an ambulance and police present. Member #5 had gone to the Housing Authority and called the police to report that parent #1 was poisoning him/her, made a storm attack him/her, and cursed him/her. Parent #2 was found yelling at the member. The police intervened. Member #5 was described as slumped over, unbalanced, pale, emotionless and staring into space. Member #5 was taken by EMS and PD to the ER. In the ER, Member #5 was in a daze, would not speak and would not move. The member continued to report parent was poisoning him/her and threatened to kill him/her and that he/she was getting weaker and dumber and losing memory due to poisoning by parent. Member #5 was able to recall all the medications given by parent. Again, the DCBS worker was called by police to member's home due to CPS incident related to medical neglect. The police

reported that the member's MH status was more severe. Member #5 appeared lethargic and meek and had written 2 letters about threats to safety and fears. The parents were reportedly not cognizant of the seriousness of the child's condition. Member #5 was taken to the ER and an IPMH mobile assessment was performed. Member #5 met the criteria for IPMH admission. The DCBS worker visited the parents to request consent for IPMH admission and was denied entry. Parent #2 refused and was told by the worker that the State would take custody if necessary. The child was felt to be at risk of not having MH needs addressed despite meeting criteria for IPMH admission. An emergency custody order was requested and granted with a Temporary Removal Hearing scheduled for 4 days later. Parent #2 refused to allow the police to take the member, became aggressive, and was arrested. Member #5 was transported to the IPMH facility and admitted. The first MCO note occurs on this date. The MCO note consists of an initial authorization for IPMH admission due to suicidal ideation, command auditory hallucinations, visual hallucinations, the belief that parents are poisoning him/her and refusal to eat, preoccupation with religion and belief that he/she was hit by lightning. A visit by DCBS worker on day #1 revealed that the member was more alert, eating and talking but had not bathed or changed clothes and did not want to see parents. The Temporary Removal Hearing was held and the member remained in the custody of the State. An MCO review on day #4 authorized continued stay. An MCO review day #5 noted a call that was made and message left for DCBS and there was an MCO MD recommendation for further treatment at a residential setting once stabilized. On day #7, continued stay was authorized. A DCBS visit on day #12 revealed that the member still refused to shower or use the toilet due to the belief that there were cameras in the bathroom. The treatment plan was to ensure that the member began to eat, drink, and take meds correctly prior to discharge. An MCO continued stay review on day #12 resulted in referral for MD review. Continued stay was denied due to limited progress, refusing medications with no plan for court intervention, and not posing harm to self or others, with 2 days allowed for discharge planning. An expedited appeal resulted in the decision being overturned due to acute continued psychosis and paranoia, not eating, need for acute stabilization at IPMH level of care and plan for facility MD to obtain outpatient commitment to take medications. The discharge plan was for therapeutic foster care with DCBS as guardian. A DCBS note on day #13 revealed that Member #5 was still not eating or drinking and medications were still being adjusted. MCO UR was done on day #13 with continued stay authorized. The MCO requested that facility consider "MH EPSDT". MCO UR was done on day #14 and indicated that Member #5 was still paranoid, still refused to shower due to the belief of a camera in the bathroom, was not happy on the unit (low functioning), but was more compliant with meds and the discharge plan was "per DCBS". This was the final MCO note. DCBS notes for days #19 & #21 indicated that Member #5 began to eat, drink, sleep better, and shower and wanted to see his parents and family therapy would begin. On day #29, Member #5 was placed in a Private Child Care/Therapeutic Foster Care (PCC/TFC) home. DCBS notes indicated that Member #5 continued in this home for the remainder of 2014, continued receiving therapy, attended regular school and was passing all classes, participated in sports, had supervised visitation with parents, and was getting along well with everyone in the foster home.

DCBS notes demonstrated that the member was followed from prior to the first admission through the end of 12/2014. MCO notes were initiated with the authorization for IPMH admission. Subsequent MCO notes were related solely to utilization review functions and there was a notation of communication with DCBS. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. There was no evidence of coordination of care/continuity of care other than UM activities. The final MCO note occurred prior to discharge, on day #14 of the IPMH admission. There was some evidence that the MCO followed discharge planning; however the MCO notes ended prior to final discharge arrangements being made. There was no documentation by the MCO after the member's discharge to the foster home. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Case 5: IPRO recommendation:

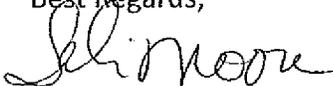
Despite a denial of continued stay, continue to coordinate with DCBS regarding the member's status and needs.

MCO response:

The admissions were for Inpatient and step down to extended care, therefore the IP admission was HEDIS exclusion and it did not trigger an automatic follow up by CM. CoventryCares of Kentucky agrees that this is a best practice to ensure positive member outcomes. Recently, and as part of the new integration of BH and PH the concurrent review team for BH is referring those members who have been decertified to the integrated care management team for outreach and coordination of care.

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**

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Lisa D. Lee
Commissioner

November 2, 2015

Sabrina Moore
Terence L. Byrd
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016FC-1

Dear Ms. Moore and Mr. Byrd:

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

Identifying #	Contract Section	DEFICIENCY
CC2016FC-1	Section 36.2	Failure to ensure access to care coordination for all DCBS clients.

After reviewing your MCO's response we were unable to locate a detailed plan to ensure future compliance and an implementation date (time and manner) as requested in our September 21th letter. Coventry failed to submit a plan that will ensure that they will incorporate all of IPROs recommendations.

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.

Pursuant to Section 40.4 of the Contract, Coventry 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.

We look forward to receiving Coventry'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



11/16/15

Via Mail

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

Re: Request for Corrective Action Plan- CC2015FC-1

Dear Mr. McAnally:

Please accept this correspondence in response to your original notification dated November 2, 2015 rejecting a Corrective Action Plan for the following cited deficiency:

Identifying #	Contract Section	DEFICIENCY
CC2015FC-1	Section 36.2	Failure to ensure access to care coordination for all DCBS clients.

CoventryCares has updated its original response to include dates process implementation will occur or has indicated that the process is currently being utilized. CoventryCares has taken iPro's recommendations into consideration and has either implemented new processes or further illustrated how we are currently meeting contract compliance. IPro's recommendations are inexact therefore CoventryCares has referred back to the contract to ensure we are in compliance with the Kentucky Medicaid Managed Care Contract. Please see the updated response below.

Case #1

Member #1 was a teen with diagnoses of history of neglect and sexual abuse; sexual disorder/deviation; other episodic mood disorder; impulse control disorder; hyperkinesis with developmental delay; mental retardation/IQ 52-55; cerebral palsy; asthma; who was born premature and addicted to cocaine.

Member #1 had 2 admissions during the period reviewed; one psychiatric residential treatment facility (PRTF) sexual offender treatment program (SOTP) admission for 152 days and one out-of-state (OOS) PRTF/inpatient mental health (IPMH) admission for 61 days.

Member #1 was living with adoptive family and was followed by DCBS due to inadequate supervision and hoarding (by adoptive family). Member #1 had incidents of sexual offending against adoptive siblings who were then placed in temporary foster care. Member #1 was removed to PRTF #1, with an estimated length of stay (LOS) of 3-6 months. During PRTF #1 stay, member had inappropriate sexual behaviors, oppositional-defiant behaviors, aggressive and destructive behaviors. Continued stay was denied on the 56th day due to limited progress in therapy with only temporary improvement, with 2 days allowed for discharge planning. An expedited appeal upheld the decision. A subsequent conference call with the MCO, facility #1, and DCBS resulted in the denial being overturned. There was no documentation in the MCO or DCBS records regarding the specifics of this call. The following day, Member #1 committed a sexual offense against a peer. Member #1 continued treatment at PRTF #1 due to lack of appropriate placement options, possible out of state placement, and the need for very close supervision. On the 111th day, continued stay was again denied and the MD reviewer recommended that the member needed a program for low IQ, specifically. An expedited appeal upheld the decision.

Member #1 remained at the facility pending possible placement at an OOS facility. On the 151st day, the admissions department at the OOS facility #2 was contacted. The member was transferred to the OOS facility #2 on the 154th day with an estimated LOS of 30 days and a plan to discharge to adoptive parent. There was some question whether the adoptive parent fully understood the risk of having member in the home and possessed the ability to adequately supervise the member. During this admission, there was a confirmed quality of care issue identified by the MCO. Facility #2 submitted a corrective action plan. On the 61st day, Member #1 was discharged to the adoptive parent with home services and outpatient behavioral health (BH) treatment, including individual and family therapy. Member #1's siblings were living outside the adoptive home but there were suspected incidents of sexual offending against 1 sibling and a peer at school.

DCBS notes demonstrated that the member was followed from prior to the first admission through discharge home with outpatient therapy until 12/2014. MCO notes were initiated at the time of the first admission through second admission but were related solely to utilization review (UR) functions. There was one MCO note after the second discharge, but it was an authorization for outpatient BH therapy only. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no evidence of coordination of care/continuity of care other than utilization management (UM) activities. There was no documentation by the MCO after the member's discharge to the adoptive home, except the outpatient authorization. There was evidence of some participation in discharge planning. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Member #1 remained at the facility pending possible placement at an OOS facility. On the 151st day, the admissions department at the OOS facility #2 was contacted. The member was transferred to the OOS facility #2 on the 154th day with an estimated LOS of 30 days and a plan to discharge to adoptive parent. There was some question whether the adoptive parent fully

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understood the risk of having member in the home and possessed the ability to adequately supervise the member. During this admission, there was a confirmed quality of care issue identified by the MCO. Facility #2 submitted a corrective action plan. On the 61st day, Member #1 was discharged to the adoptive parent with home services and outpatient behavioral health (BH) treatment, including individual and family therapy. Member #1's siblings were living outside the adoptive home but there were suspected incidents of sexual offending against 1 sibling and a peer at school.

DCBS notes demonstrated that the member was followed from prior to the first admission through discharge home with outpatient therapy until 12/2014. MCO notes were initiated at the time of the first admission through second admission but were related solely to utilization review (UR) functions. There was one MCO note after the second discharge, but it was an authorization for outpatient BH therapy only. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no evidence of coordination of care/continuity of care other than utilization management (UM) activities. There was no documentation by the MCO after the member's discharge to the adoptive home, except the outpatient authorization. There was evidence of some participation in discharge planning. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case 1: iPro recommendation:

Implement improvements to the process for case management for DCBS members with BH conditions and frequent admissions and those who are hard to place and maintain active involvement in these cases.

MCO response:

Both admissions were long term residential treatment, which does not qualify for HEDIS follow up measure so there, is not an automatic trigger for CM outreach. CoventryCares of Kentucky will enhance their current policy and processes by January 1, 2016. CoventryCares is in the process of creating a robust integrated care management program. Training is ongoing and a gap analysis is ongoing to improve the coordination of care and communications with the facilities and DCBS. CoventryCares of KY has a policy CM-011, "Case Management for Members in Foster Care and Members who are receiving Adoption Services" and upon review, it is the belief of the MCO that the enhancements will strengthen the integrated care management program while offering more coordination of care to the DCBS population.

Case #2

Member #2 was a teen with diagnoses of sexual offender; unspecified psychosexual disorder; history of possible sexual abuse; impulse control disorder; asthma; and other ill-defined and unknown causes of morbidity and mortality. Member #2 had 3 admissions during the review period; one residential treatment center (RTC) SOTP for > 1 year (~ 16 months), one RTC SOTP for 44 days, and one residential children's center (RCC) with SO treatment for ~ 71 days. The first RTC SOTP admission began prior to enrollment with the MCO; but the member was

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enrolled in the MCO for 304 days through discharge from this facility. There were only DCBS notes for this portion of the review period.

Member #2 was born to a teen mom, had never met father, raised by grandparents, and had three siblings. Member #2 lived with mother, her husband, younger half-sibling and maternal grandparents. During 2012, Member #2 and sibling were placed in State custody due to domestic violence. Foster family raised concerns regarding sexual offending (SO). There was law enforcement/legal involvement. At some point, Member #2 lived with Aunt who denied any SO events. Admitted to facility #1 and failed treatment there with incident(s) of SO against peer(s). Member #2 was transferred from facility #1 to facility #2. Member #2 admitted to RTC SOTP #2 with estimated LOS 9 months and discharge plan of Coventry-DCBS-BH-DeCert-
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DCBS placement, Aunt's custody, or with family in Florida. Member made some progress at RTC SOTP #2, but showed disobedience/defiance, inappropriate behaviors, and hoarding. A quality of care issue was confirmed by the MCO at facility #2, with no response from the facility. Continued RTC SOTP #2 stay was denied on day #42 due to lack of medical necessity, not reasonably expected to improve under treatment plan and documentation does not support program protocol, with 2 days for discharge planning. MD reviewer recommended group home setting, outpatient treatment for SO, and family therapy. An expedited appeal was filed, supported by DCBS and DPP, with denial upheld. As a result of the continued stay denial, Member #2 was transferred to RCC with SO treatment on day # 55, with a discharge plan to return to parent or therapeutic foster home. On day #153, the discharge goal was changed to adoption. DCBS notes ended as of 12/2014, with member progressing through the SO program and attending public school and with a discharge plan to either return to parent, foster care, or adoption.

DCBS notes demonstrated that the member was followed from RTC SOTP #1 through end of review period. There were no MCO notes provided for the first admission, although the member was enrolled in the MCO for the majority of that admission. MCO notes were initiated at the time of transfer from RTC SOTP #1 to #2. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. MCO notes were related solely to UR functions. There were no MCO notes after transfer from RTC SOTP #2 to RCC. During the RCC admission, MCO documentation included only an authorization for outpatient BH therapy. There was no evidence of coordination of care/continuity of care other than UM and only for the period during RTC SOTP #2 stay. The member was followed by the MCO only during RTC SOTP #2 stay. Transfer to RCC was the result of denial of continued stay at RTC SOTP #2. The UM decisions were timely and appropriately documented. As described, the MCO identified a quality of care issue at one of the facilities.

Case 2: iPro recommendation:

Upon notification of a BH admission, immediately begin coordinating care with the facility and DCBS.

MCO response:

The admission was for residential treatment, which does not qualify for a HEDIS follow up measure, so it does not automatically trigger CM outreach. CoventryCares of Kentucky has developed a daily census report that includes a specific tab for the foster care population. This allows immediate outreach to the facility as well as an agenda item at the DCBS meetings. The utilization of this tool is currently a part of the case management referral process. The integration of BH into the physical health CM department is a new process.

Case #3

Member #3 was a teen with diagnoses of bipolar disorder; mild mental retardation/IQ 61; ADHD with hyperactivity; unspecified hyperkinetic syndrome; unspecified disturbance of conduct; anxiety; other specified episodic mood disorder; other unknown and unspecified cause of morbidity and mortality; seizure disorder; rule out medication side effects and akathisia; constipation; and seasonal allergies.

Member #3 had 4 admissions with periods of elopement/away without leave (AWOL) in 2 facilities during the review period: one IPMH admission at facility #1 for 12 days; one admission at facility #2 at both IPMH and PTRF levels of care for 23 days, one admission at facility #2 at both PTRF and IPMH levels of care for 187 days (denied after day #170); and one admission at facility #2 at the PTRF level of care for 54 days (denied in its entirety). Coventry-DCBS-BH-DeCert-Case_Review_Summary_Report_FINAL7 23 15 Page 5 of 14

Member #3 was residing at a children's home as a result of being removed from parents' custody due to physical abuse and neglect and relinquishing parental rights in 2009. Siblings remained with one of the parents. Member #3 had been in foster care but family could not meet his/her mental health needs. Member #3 had a prior history of 2 IPMH admissions in 2012. Member #3 was said to be compliant with medications. Member #3 was admitted emergently to IPMH for severe aggression and self harm. MCO note at this time stated "Coordination of Care referral: No." Upon admission, the children's home gave notice that they would not accept the member back upon discharge. MCO note stated that PRTF placement should be considered on discharge and possible placement issues. During this stay, the member was noted to be physically aggressive to staff, peer(s), and self, had destructive behaviors and manic behavior and speech, and continuously described wanting a family. Member #3 transferred to PRTF at facility #2 with an estimated LOS of 6 months and discharge plan "per DCBS". During the stay at facility #2, the member displayed verbal and physical aggression toward staff and peers, destructive behaviors, sexual acting out and was transferred from PRTF to IPMH level of care at facility #2 for 8 days due to suicidal ideation/gesture, homicidal ideation with no plan, multiple elopement incidents, criminal behavior with law enforcement involvement, with a plan to transfer back to PTRF level of care. During the IPMH period, the member had manic behavior and reported visual and auditory hallucinations. The MCO noted telephone outreach DCBS at this time. There was a gap in the MCO documentation for 3 days during this IPMH admission and authorization information was not available. MCO notes resumed with the IPMH admission to facility #2. The notes indicated that the member was

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AWOL from PTRF and displayed physical aggression toward staff requiring injected medications. During this IPMH stay, Member #3 was verbally and physically aggressive requiring restraint and expressed anger due to DCBS not finding a new family. The plan was to transfer back to the PTRF. An MCO email indicated the member needed a new placement situation, obtaining updated information from DCBS, and sending out referrals. There was a gap in the MCO documentation for 9 days during this period of the IPMH/PTRF stay and authorization information was not available. MCO notes resumed when the member was admitted to the PTRF. DCBS notes indicated that an adoptive family was being sought and the member would have outings with the DCBS worker when ready. DCBS described an issue with facility #2 regarding ordering/administering seizure medications and that the seizure activity was atypical and might have been contributing to the members behavioral issues. Member #3 displayed aggression, self-injuring behaviors, AWOL activity, sexual acting out, suicidal and homicidal ideation, and property destruction. There was no update available on the discharge plan. The MCO noted concerns about the limited number of individual therapy sessions occurring and the facility's lack of attempts to contact DCBS. DCBS conducted pre-placement consultation for a prospective foster/adoptive family. Member #3 continued to have periods of aggression and inappropriate behaviors but showed some improvement in mood, affect, insight, judgment with improved behavior and motivation due to attempts to find a family placement. Phone calls and visits by the prospective family continued. Facility #2 noted considerably better behavior after family visits, but has episodes of aggression and inappropriate behaviors at times.

Member #3 expressed concerns regarding foster/adoptive family's plan to move out of state. Member #3 with continued behavioral issues/AWOL, and it was stated this might be due to missing the foster/adoptive family and their living out of state. Member #3 expressed the desire to be discharged to the adoptive family. There was an extended wait for the adoption approval due to the inter-state process. On day # 153 the MCO sent the case to UM MD review. Continued stay was denied due to the member did not meet medical necessity criteria, clarification regarding discharge plan/foster family placement was needed, and limited progress despite extended treatment time. Two days later, Member #3 was emergently admitted to IPMH LOC at facility #2 due to suicidal ideation with plan. The member was transferred back to the PTRF after 2 days. Another UM MD referral was completed. Continued stay was denied due to the member did not meet medical necessity criteria, behaviors were chronic, the member had not made progress, there was no reasonable expectation of benefit from continued treatment, it was unclear if the discharge plan to OOS foster family was being pursued, the member remained at IP LOC due to discharge disposition/custodial issues only, with 2 days allowed for discharge planning. The MD Reviewer recommended transition to community-based level of care with intensive services. An expedited appeal was filed and the decision was upheld. There was a 1 day gap in the MCO documentation during this admission and authorization information not available. MCO notes resumed with an emergent IPMH admission post AWOL from PTRF. Member #3 displayed physical aggression, property destruction, and self-injuring. PTRF facility #2 declined to accept the member back. During this time, Member #3 reported not wanting to go to PTRF, instead, wanted to go home to adoptive

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family. The MCO noted that a Coordination of Care referral was made; however, there was no related documentation. The discharge plan continued to be OOS foster/adoptive family, once approved. DCBS requested an expedited approval for the adoption as the member's behaviors appeared to be related to delayed placement with the adoptive family. An MCO note indicated that since PRTF would not accept the member back, DCBS desired that the member to stay in IPMH LOC until the adoption approval process was completed and the member could be discharged to the adoptive family. There were notation(s) of MCO attempt(s) to contact DCBS regarding the discharge plan. On day #6, the case was sent for UM MD review. Continued stay was denied as of day #7 due to the member was doing well at the IPMH LOC with no acute symptoms and did not meet medical necessity criteria and a recommended discharge plan of step-down to PTRF and placement OOS, with 2 days allowed for discharge planning. An expedited appeal was filed and the decision was upheld. The facility indicated that an appeal would be filed for all days denied after final discharge. After the IPMH continued stay denial, there was a gap in the MCO documentation for 16 days. MCO notes resumed with review of a pre-certification request for PRTF admission at facility #2 due to physical aggression, manic behavior, and anxiety regarding discharge placement. The MCO noted the prior PRTF denial due to baseline status/maintained for placement only. The case was sent for UM MD review. The PRTF admission was denied due to the prior PRTF stay of 153 days with subsequent emergent IPMH admission. The MCO noted that the member did not meet medical necessity criteria as the behaviors were baseline and the member had reached maximum benefit from treatment. The MD recommended treatment in a community setting with supports for patients with mental retardation and behavior issues. There were no further MCO notes after this, although there was a DCBS notation of a subsequent PRTF stay approval ~ 1 week later. Subsequent DCBS notes through 12/2014 stated that the member was in PRTF, was communicating with the adoptive family, and the approval for the adoption was still pending. The member had a one week visit at family's OOS home which was extended. The adoption was approved in 12/2014 and Member #3 was officially discharged from the PRTF. DCBS notes included a note in 1/2014, prior to IPMH admission #1. There were no MCO notes prior to IPMH admission #1. MCO notes were initiated upon the first IPMH admission to facility #1. The MCO documentation included assessments from admitting facilities. There was no care plan. MCO notes were related solely to UR functions. There were 3 gaps in MCO documentation where authorization information was not available. There were no MCO notes after the pre-certification denial for the last PRTF admission. There was some evidence of coordination of care with DCBS. Regarding continuity of care, as described, there were gaps in documentation and no MCO notes after the final pre-certification denial for PRTF admission. There was some MCO participation in discharge planning; however, notably, MCO documentation was absent for the final PRTF admission through final discharge/permanent placement of the member with the adoptive family. The UM decisions were timely and appropriately documented. As described, the MCO (both RN reviewer and MD reviewer) identified a potential quality of care issue at one of the facilities and the MCO contacted the facility. The issue was not confirmed, so it appears it was corrected.

A noteworthy observation is that both the MCO and the DCBS documentation (and the included facility notes) suggested that the member was angry due to having been abandoned by biological family and had difficulty coping with that and being confined to a facility. The member expressed anger through aggressive verbal and physical behaviors, self injuring, sexual acting out, stealing, hoarding, and running away. This appeared to be complicated by a seizure disorder, ADHD, and mild MR. The member was eventually able to communicate this and communicated the desire to live with a family in a home with a yard and a dog. Also, the member's behavior was considerably better when there was positive news about placement with the adoptive family or when there were family visits and communications.

Case 3: iPro recommendation:

Analyze claims data to identify DCBS members and other pediatric members with BH conditions and conduct outreach, assessments, and initiate care management activities where needed.

MCO response:

Multiple inpatient admits to extended care and then to residential treatment and back to inpatient care and each was HEDIS exclusion upon discharge. However, multiple documents related to Susan's communication with DCBS were submitted. CoventryCares of Kentucky currently incorporates data analysis into the identification process of our members who may be candidates for case management. Claims information related to all Foster Care members is currently shared with DCBS in monthly meetings at the state. Policy CM-017, "Case Management of Persons with Special Needs" states identification includes claim data. BH prior authorization process and their subsequent referrals are part of the integration of BH and PH in the CM department.

Case #4

Member #4 was a teen with diagnoses of ADHD; bipolar disorder; mild mental retardation/IQ 71; unspecified episodic mood disorder; other conduct disorder; other unknown and unspecified cause of morbidity and mortality; sexual offender; history of substance abuse; rule out post-traumatic stress disorder, and with a history of parental emotional abuse and sexual abuse by an adult (non-relative).

Member #4 had ~ 10 admissions during the review period at 5 facilities; one elopement with a brief stay at an emergency shelter for children (facility #1) for 2 days; one RTF admission (facility #2) for 40 days, one IPMH admission (facility #3) for 2 days; one RTF admission (facility #2) for 19 days, one IPMH admission (facility #4) for 22 days; one RTF admission (facility #5) for 148 days; one elopement with a brief stay at an emergency shelter for children (facility #1) for 6 days; one RTF admission (facility #5) for 17 days; one elopement for 1 day; and one RTF admission (facility #5) for the remainder of 2014, 36 days.

Member #4 lived with a parent from birth until 13 years of age; with different relatives for 1 year; spent some time living with grandparent and ran away; was placed in a residential treatment setting for sexual offenders for 1 year; and was then transferred to another RTF after

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elopement. Member #4 had sibling(s) who lived with parent. DCBS was involved due to behaviors including verbal and physical aggression, inappropriate sexual behaviors, defiance, sneaking out of home, substance and alcohol abuse, truancy, and law enforcement involvement. Member #4 was a sexual offender on probation until age 18 with a history of charges for resisting arrest and contempt of court.

MCO documentation prior to the first RTF elopement incident included only authorizations for outpatient BH treatment and targeted BH case management. Notes from the targeted BH case management were not included. DCBS notes indicated that Member #4 was in treatment through DCBS referral and working toward family reunification. Upon elopement, DCBS met with Member #4 at the emergency shelter and the member was admitted to RTF admission at facility #2. The only MCO notes continued to be service authorizations. The member had suicidal ideation and uncontrollable behaviors during RTF admission (facility #2) and was admitted to IPMH (facility #3) for 2 days. The only MCO note was for IPMH authorization. The member was discharged to RTF (facility #2) but continued defiant behavior, verbally and physically aggressive behaviors requiring physical management, sexually inappropriate behaviors, and AWOL attempts, but participated in therapy, had positive phone calls with parent, maintained good grades in school and was able to make some progress with substance abuse treatment. Member #4 continued to express not wanting to be in RTF and desire to go home to parent, not grandparent. Member #4 had a second IPMH admission (facility #4) due to suicidal ideation, self-injuring, and unmanageable behaviors with estimated LOS of 18 days and plan to discharge back to RTF (facility #2). There was an MCO note regarding IPMH authorization and continued stay reviews and MCO notes regarding attempted contact with DCBS (2 times). The PRTF (facility #2) indicated that the member would not be accepted back. On day #3, there was an MCO referral for MD review. The MD reviewer completed a peer-to-peer discussion and continued stay was denied due to lack of medical necessity, with 2 days allowed for discharge planning and MD recommendation that needs could be met with OPMH treatment and appropriate placement. DCBS/MCO communications indicated that DCBS sought RTF placements statewide and all were rejected, except 1 with no response. Member #4 was being considered for RTF at facility #5, but there was a long waiting list. Conference call(s) to discuss placement were scheduled and call was held with DCBS, IPMH facility, and 2 other agencies (not MCO). Member continued stay at IPMH facility despite decertification/continued stay denial. The facility later appealed the decision and the denial was upheld. On day #37, a DCBS note indicated that the member was accepted at RTF facility #5 but was on the wait list. Member #4 continued to express the desire to return to parent and had phone contact with parent. Parent was unable to visit. Member was reportedly fighting with peers and "cheeking" medications. The member was discharged to RTF facility #5. On day #4, an incident occurred where member stripped, physically attacked staff, made sexually inappropriate comments to staff, and indicated desire to AWOL to get high. The parent was invited to participate in therapy but did not respond and this indicated the viability of reunification was unknown. On day #20, the member was making progress with therapy and maintaining good grades with discharge goal of returning to parent. The member still had inappropriate sexual gestures, aggressive

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behavior, and struggles with drug cravings. During this RTF stay, Member #4 had ongoing issues with aggression, inappropriate sexual behavior, and self-harm, AWOL plots, drug cravings and required physical intervention, isolation, and seclusion but was making some progress in therapy with periods of improved behavior. As of day #146, the member was showing improvement, was off AWOL precautions, and parent was participating in some therapy, with a home visit being considered. On day #148, the member went AWOL for 6 days with a brief stay at the emergency shelter for children. Member #4 had confirmed drug use and sexual activity during this AWOL event. Member #4 was returned to RTF (facility #5). The member's behaviors continued same as before and there was another incident of AWOL for 1 day on day #17 with the member returned to the RTF (facility #5). There was noted confirmed promiscuity and a positive test for cocaine. During this continued RTF stay, Member #4 had ongoing issues with defiance, verbal and physical aggression requiring physical intervention, restraint, isolation, and seclusion, and drug cravings. A new substance abuse treatment program was initiated. Member #4 inquired about plans for the future and was told that improved behavior was necessary in order to earn a home visit and transfer to an independent living (IL) cottage, though this would not occur soon. The discharge plan was a transfer to a step-down residential setting or foster care before being released home. The member had a court ordered commitment until age 18 due to unpredictable behavior and the parent's instability. The member maintained contact with both parents, one regularly, the other sporadically; however, the parent was making limited efforts toward reunification. Member #4 was a high risk due to unpredictable behaviors, immaturity, use of body to get drugs and putting self in dangerous situations. As of the end of 2014, the member began making some progress in treatment, showed increased motivation, improved moods and behaviors, and had stronger performance in school. The member was in contact with parent and siblings via phone. There were some parent visits at the facility, but the parent continued to have minimal involvement in therapy. The discharge plan remained transfer to step-down program/pre-independent living followed by unification with family after court order commitment ended. DCBS notes demonstrated that the member was followed from prior to January 2014 through December 2014, where the period of review ended. MCO notes for the beginning of review period were limited to service authorizations. More substantive MCO notes were seen after the second IPMH admission and return to RTF, where there were IPMH authorizations, continued stay reviews, and notes regarding contact attempt(s) with DCBS. However, most of the MCO notes appeared to be related solely to UR functions. The MCO documentation included assessments as communicated by the admitting facilities. There was no care plan. There was no real evidence of coordination of care and services other than UM activities. Continuity of care activity was limited, as was participation in discharge planning. It is particularly notable that there were no MCO notes after continued stay at the RTF was denied, except a few emails among DCBS, the MCO, and "Bluegrass" after the last covered RTF day and notation of the IPMH appeal. This is despite the occurrence of a number of significant events during the subsequent timeframe. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Case 4: iPro recommendation:

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Ensure continuity of care for DCBS members with BH admissions by actively participating in discharge planning, ensuring post-discharge follow-up care is provided, and continuing to monitor the member's status post-discharge.

MCO response:

Only two of the ten documented admissions were eligible for Medicaid MCO reimbursement, the other placements were via DCBS and each admission was HEDIS exclusion upon discharge, which did not trigger an automatic CM outreach. Case management currently participates in weekly meetings with all four (4) of the inpatient psychiatric facilities to discuss members who are or will be discharging in an effort to ensure post-discharge follow-up care is provided, and continuing to monitor the member's status post-discharge. Communication is ongoing until discharge or placement and then transition of care to the MCO is facilitated. BH discharge meetings were recently transitioned to the physical health case management team as part of the integration process.

Case #5

Member #5 was a teen with diagnoses of psychiatric disorder NOS; unspecified psychosis; other unknown and unspecified cause of morbidity and mortality. One of the member's parents had a diagnosis of schizophrenia and the other had alcoholism.

Member #5 had 1 IPMH admission for 29 days during the period reviewed.

Member #5 had 1 IPMH admission for 29 days during the period reviewed.

Member #5 was introduced to DCBS due a CPS incident related to risk of harm, neglect, physical assault/injury ~ 1 month prior to IPMH admission. DCBS met Member #5 at an adult friend's home (specific relationship not stated), where the member had been staying for 5-6 days.

Member #5 stated that he liked to stay at this friend's home due to it was a quieter neighborhood and this adult never tries to harm member. The adult reported that the member did not eat much. Member #5 claimed he went to the hospital because his parent hit him in the stomach. This could not be confirmed by the adult friend. The adult reported that he took the member on an outing with parents' permission and the member complained of a stomach ache. An interview with 1 parent revealed that the parent was worried about complaints of stomach ache, took member to ER, and the doctor gave them medication. This parent reported that they do not hit the member for discipline and they were worried about "nerves". The other parent refused to be interviewed at that time. A later interview with parent #2 confirmed the information provided by parent #1. Parent #2 also reported that Member #5 has trouble with "nerves" and was seen at clinic, got medication and is better. The clinic confirmed seeing the member. The clinic doctor stated that parents were asked to take Member #5 for therapy and was told by parent #2 that the member already saw a therapist. A second CPS incident, ~ 1 month after the first, related to medical neglect. The DCBS worker was called to Member #5's home where there was an ambulance and police present. Member #5 had gone to the Housing Authority and called the police to report that parent #1 was poisoning him/her, made a storm attack him/her, and cursed him/her. Parent #2 was found yelling at the member. The police intervened. Member #5 was described as slumped over,

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unbalanced, pale, emotionless and staring into space. Member #5 was taken by EMS and PD to the ER. In the ER, Member #5 was in a daze, would not speak and would not move. The member continued to report parent was poisoning him/her and threatened to kill him/her and that he/she was getting weaker and dumber and losing memory due to poisoning by parent. Member #5 was able to recall all the medications given by parent. Again, the DCBS worker was called by police to member's home due to CPS incident related to medical neglect. The police reported that the member's MH status was more severe. Member #5 appeared lethargic and meek and had written 2 letters about threats to safety and fears. The parents were reportedly not cognizant of the seriousness of the child's condition. Member #5 was taken to the ER and an IPMH mobile assessment was performed. Member #5 met the criteria for IPMH admission. The DCBS worker visited the parents to request consent for IPMH admission and was denied entry. Parent #2 refused and was told by the worker that the State would take custody if necessary. The child was felt to be at risk of not having MH needs addressed despite meeting criteria for IPMH admission. An emergency custody order was requested and granted with a Temporary Removal Hearing scheduled for 4 days later. Parent #2 refused to allow the police to take the member, became aggressive, and was arrested. Member #5 was transported to the IPMH facility and admitted. The first MCO note occurs on this date. The MCO note consists of an initial authorization for IPMH admission due to suicidal ideation, command auditory hallucinations, visual hallucinations, the belief that parents are poisoning him/her and refusal to eat, preoccupation with religion and belief that he/she was hit by lightning. A visit by DCBS worker on day #1 revealed that the member was more alert, eating and talking but had not bathed or changed clothes and did not want to see parents. The Temporary Removal Hearing was held and the member remained in the custody of the State. An MCO review on day #4 authorized continued stay. An MCO review day #5 noted a call that was made and message left for DCBS and there was an MCO MD recommendation for further treatment at a residential setting once stabilized. On day #7, continued stay was authorized. A DCBS visit on day #12 revealed that the member still refused to shower or use the toilet due to the belief that there were cameras in the bathroom. The treatment plan was to ensure that the member began to eat, drink, and take meds correctly prior to discharge. An MCO continued stay review on day #12 resulted in referral for MD review. Continued stay was denied due to limited progress, refusing medications with no plan for court intervention, and not posing harm to self or others, with 2 days allowed for discharge planning. An expedited appeal resulted in the decision being overturned due to acute continued psychosis and paranoia, not eating, need for acute stabilization at IPMH level of care and plan for facility MD to obtain outpatient commitment to take medications. The discharge plan was for therapeutic foster care with DCBS as guardian. A DCBS note on day #13 revealed that Member #5 was still not eating or drinking and medications were still being adjusted. MCO UR was done on day #13 with continued stay authorized. The MCO requested that facility consider "MH EPSDT". MCO UR was done on day #14 and indicated that Member #5 was still paranoid, still refused to shower due to the belief of a camera in the bathroom, was not happy on the unit (low functioning), but was more compliant with meds and the discharge plan was "per DCBS". This was the final MCO note. DCBS notes for days #19 & #21 indicated that Member #5 began to eat, drink, sleep better, and

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shower and wanted to see his parents and family therapy would begin. On day #29, Member #5 was placed in a Private Child Care/Therapeutic Foster Care (PCC/TFC) home. DCBS notes indicated that Member #5 continued in this home for the remainder of 2014, continued receiving therapy, attended regular school and was passing all classes, participated in sports, had supervised visitation with parents, and was getting along well with everyone in the foster home.

DCBS notes demonstrated that the member was followed from prior to the first admission through the end of 12/2014. MCO notes were initiated with the authorization for IPMH admission. Subsequent MCO notes were related solely to utilization review functions and there was a notation of communication with DCBS. The MCO documentation included assessments as communicated by the admitting facility. There was no care plan. There was no evidence of coordination of care/continuity of care other than UM activities. The final MCO note occurred prior to discharge, on day #14 of the IPMH admission. There was some evidence that the MCO followed discharge planning; however the MCO notes ended prior to final discharge arrangements being made. There was no documentation by the MCO after the member's discharge to the foster home. The UM decisions were timely and appropriately documented. No potential quality of care issue was identified.

Case 5: IPRO recommendation:

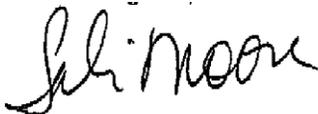
Despite a denial of continued stay, continue to coordinate with DCBS regarding the member's status and needs.

MCO response:

The admissions were for Inpatient and step down to extended care, therefore the IP admission was HEDIS exclusion and it did not trigger an automatic follow up by CM. CoventryCares of Kentucky agrees that this is a best practice to ensure positive member outcomes. Currently, and as part of the new integration of BH and PH the concurrent review team for BH is referring those members who have been decertified to the integrated care management team for outreach and coordination of care.

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**

Steven L. Beshear
Governor

Division of Program Quality & Outcomes
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Audrey Tayse Haynes
Secretary

Cindy Arflack
Director

Lisa D. Lee
Commissioner

December 4, 2015

Sabrina Moore
Terence L. Byrd
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016FC-1

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of Coventry's response developed for CC2016FC-1 (Section 36.2 Failure to ensure access to care coordination for all DCBS clients) dated November 16, 2015.

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

Coventry is required to must implement and provide ongoing care coordination with the Departments for Community Based Services (DCBS) and Aging and Independent Living (DAIL) for members who are adult guardianship clients or foster care children and identified as Individuals with Special Health Care Needs (ISHCN). This is to ensure that members, whether or not they are enrolled in case management, have access to needed social, community, medical, and behavioral health services and is not dependent on whether those services are HEDIS measures. This also requires comprehensive documentation by Coventry for all services undertaken on behalf of the member.

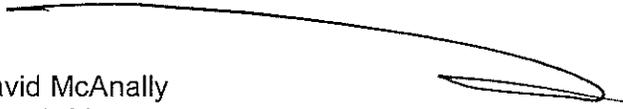
Coventry shall develop and implement policies and procedures to ensure access to care coordination for all DCBS and DAIL clients. It shall also track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to its DCBS and DAIL population.

Please also note that the Division is monitoring these cases for compliance as specified in Section 36.4 (The decertification notification shall include the Member name, Member ID, facility name, level of care, discharge plan and date of next follow-up appointment). Failure to comply with the contractual provisions may result in further action by the Department.



As you are aware this deficiency has been assigned a unique identifier. If Coventry does not agree with these conditions of acceptance, please contact the Cabinet within ten (10) business days. If we may be of any additional assistance, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "David McAnally", with a long horizontal stroke extending to the left.

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



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear
Governor**

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**Audrey Tayse Haynes
Secretary**

**Cindy Arflack
Director**

**Lisa D. Lee
Commissioner**

November 10, 2015

Sabrina Moore
Terrance Byrd
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016TPL-1

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016TPL-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.
	Section 14.2 Third Party Liability & 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 Coventry submitting the Third Party Liability (TPL) Resource File. The examples are as follows:

MCOs were notified in January 2015 via IT conference calls that the TPL Resource File that was currently due by the 15th of every month, was going to be due on or before the 8th of every month beginning October 2015. There were numerous times on the IT calls that each MCO was reminded of this change in due date for the TPL Resource file submission. 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. Coventry has had this on their IT notes since July. Coventry was reminded on the October 6th IT conference call about Thursday the 8th and they stated they had sent the file on Monday the 5th. On October 9th, 2015 an email was generated to Coventry. Coventry replied on October 9, 2015 stating "My apologies. We submitted the file on Monday. When we received your e-mail today, we inquired and found the file was not named appropriately. It was resubmitted with the new file name today".

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 Coventry'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



11/18/15

Via Mail

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

Re: Request for Corrective Action Plan- CC2016TPL-1

Dear Ms. David McAnally:

Please accept this correspondence in response to your notification dated November 10, 2015 with regard to a request for a revised Corrective Action Plan for the following cited deficiency:

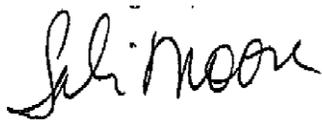
Identifying #	Contract Section	DEFICIENCY
CC2016TPL-1	21.2 Monitoring Requirements	The Contractor shall fully cooperate with the Department, its agent and/or Contractor in the contract monitoring, which includes but is not limited to: tracking and/or auditing activity, which may require the Contractor 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.
	14.2 Third Party Liability	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

Per the Department, Coventry Cares of Kentucky (CoventryCares) has had issues submitting the Third Party Liability (TPL) Resource file. The Department indicated that the TPL Resource file was not submitted timely on Monday, October the 5th.

CoventryCares in fact uploaded the TPL Resource file on October 5th, however it was incorrectly labeled. Due to human error in naming the file the file was inadvertently delayed from being received by DMS. CoventryCares received an email communication from DMS notifying us that the file was not found. CoventryCares immediately researched, renamed the file correctly, and notified DMS of the error. In an effort to ensure this will not occur in the future, staff has been reeducated and the file is now being posted several days prior to the due date to ensure that there are no further issues. CoventryCares started the process of validating that DMS has retrieved the file by checking MoveIT after it is submitted.

CoventryCares 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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Cindy Arflack
Director

Division of Program Quality & Outcomes
275 E Main St. 6 C-C
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Phone: (502) 564-9444
Fax: (502) 564-0223
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

Sabrina Moore
Terrance Byrd
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016TPL-1

Dear Ms. Moore and Mr. Byrd,

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016TPL-1 (Section 21.2 Monitoring Requirements and Section 14.2 Third Party Liability) dated November 18, 2015.

Please be advised that the response is accepted.

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

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

October 22, 2015

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

RE: CC2016PN-1

Dear Ms. Moore:

We are writing this Letter of Concern regarding the provider network file layout being incorrect as noted by DMS OATS on October 8, 2015.

The Contract states in: **APPENDIX D. MANAGEMENT INFORMATION SYSTEM REQUIREMENT**

Provider Subsystem

1. Maintain on-line audit trail of Provider names, Provider numbers (including old and new numbers, NPI), locations, and status changes by program;
2. Identify by Provider any applicable type code, NPI/TAXONOMY code, location code, practice type code, category of service code, and medical specialty and sub-specialty code which is used in the Kentucky Medicaid program, and which affects Provider billing, claim pricing, or other processing activities; The provider network file layout is incorrect. Coventry is not editing the provider network file correctly on the front end prior to sending the file to HP for processing.

The provider network file layout were:

Coventry file errors:

Record 349: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.
ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

Record 365: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.
ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

Record 366: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.

ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

Record 367: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.
ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

Record 368: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.
ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

Record 378: Rejected - Error on table "AIM"."T_PR_NETWORK", column PR_ID_MEDICAID.
ORA-12899: value too large for column "AIM"."T_PR_NETWORK"."PR_ID_MEDICAID" (actual: 15, maximum: 10)

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 case 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
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



10/26/15

Via Certified Mail

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

Re: LOC – Provider Network File 10/8/15

Dear David McAnally:

Please accept this correspondence in response to your Letter of Concern regarding CoventryCares of Kentucky's (CoventryCares) 10/8/15 Provider Network File layout errors.

In the Provider Network File submitted on 10/8/15, Dr. Muhammed Rasheed's Medicaid ID was incorrectly entered. A manual data entry error occurred where a hyphen and four digits were added to his Medicaid ID number. Effective immediately, Avēsis implemented a data entry process that prohibits the data entry of hyphens and numbers after the hyphen of a Medicaid ID number into Avēsis' operating systems. Dr. Muhammed Rasheed's Medicaid ID number is listed correctly in the provider directory. Please note, the corrected file was resubmitted to DMS OATS today via the DMS FTP site at 11:37 am.

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**

Steven L. Beshear
Governor

Division of Program Quality & Outcomes

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Audrey Tayse Haynes
Secretary

Cindy Arflack
Director

Lisa Lee
Commissioner

November 20, 2015

Sabrina Moore
Terence Byrd
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016PN-1

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016PN-1 (regarding Provider Network File specifically Appendix D. Management Information System Requirement) dated 10/26/15.

Please be advised that the response is accepted with the following clarification: Coventry is responsible for oversight of the correction of this issue (checking of the files).

Section 4.3 Delegations of Authority states:

The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor.

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

Sincerely,

A handwritten signature in black ink, appearing to read "David McAnally".

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

Lisa Lee
Commissioner

September 18, 2015

Sabrina Moore
Terrance Byrd
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016NA-1

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that CoventryCares of Kentucky ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and CoventryCares of Kentucky. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016NA-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.



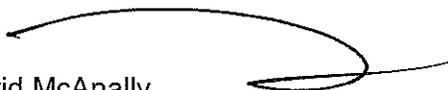
The July 2015 Network Adequacy Report shows Coventry at 94.67% for Dermatologists within the 60 mile standard of 95%. The report also shows that Coventry Health Plan had less than the 25% requirement for specialists for BHSO without residential services, BHSO including residential Services to all Members, Certified Clinical Social Worker, Endodontist, General Internist, Osteopathy, Teleradiologists, Licensed Professional Art Therapist, Licensed Behavior Analyst, Behavioral Health Multi-Specialty Group, Licensed Professional Clinical Counselor, Licensed Professional Clinical Counselor Group, Licensed Marriage & Family Therapist, Licensed Psychological Practitioner, Psychologist, Plastic Surgeon, Physical Medicine and Rehabilitation Practitioner, and Psychologist Group.

According to 29.7 Provider Program Capacity Demonstration Section C of the contract between Coventry 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 Coventry'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



10/26/15

Via Certified Mail

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

Re: LOC – Provider Network File 10/8/15

Dear David McAnally:

Please accept this correspondence in response to your Letter of Concern regarding CoventryCares of Kentucky's (CoventryCares) 10/8/15 Provider Network File layout errors.

In the Provider Network File submitted on 10/8/15, Dr. Muhammed Rasheed's Medicaid ID was incorrectly entered. A manual data entry error occurred where a hyphen and four digits were added to his Medicaid ID number. Effective immediately, Avēsis implemented a data entry process that prohibits the data entry of hyphens and numbers after the hyphen of a Medicaid ID number into Avēsis' operating systems. Dr. Muhammed Rasheed's Medicaid ID number is listed correctly in the provider directory. Please note, the corrected file was resubmitted to DMS OATS today via the DMS FTP site at 11:37 am.

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**

Division of Program Quality & Outcomes
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Steven L. Beshear
Governor

Audrey Tayse Haynes
Secretary

Cindy Arflack
Director

Lisa D. Lee
Commissioner

November 10, 2015

Sabrina Moore
Terrance Byrd
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

Re: CC2016NA-1

Dear Ms. Moore and Mr. Byrd,

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016NA-1 (Section 29.7 Provider Program Capacity Demonstration) dated October 5, 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

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Audrey Tayse Haynes
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Cindy Arflack
Director

Lisa Lee
Commissioner

November 9, 2015

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

RE: CC2016IPROP-1

Dear Ms. Moore:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016IPROP-1	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.

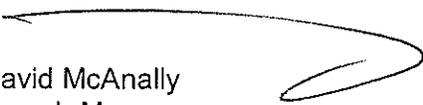
A Review of IPRO's report, *Access and Availability PCP Survey*, August 2015, identified that Coventry was non-compliant with the contract sections noted above. The following categories complied with contract obligations <80% of the time: ability to make a routine appointment with PCPs, pediatricians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



11/24/15

Via Mail

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

Re: Request for Corrective Action Plan- CC2016IPROP-1

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated November 9, 2015 with regard to a request for a Corrective Action Plan for the following cited deficiency:

Identifying #	Contract Section	DEFICIENCY
CC2016IPROP-1	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

In response to IPRO's assessment of our network access and accessibility concerns, CoventryCares has implemented the following actions. CoventryCares has provided outreach and education to all providers who stated they were not taking additional CoventryCares members. CoventryCares is in the process of updating closed panels, updated specialty information, and terminations. All changes and updates received will be reflected in our internal system and a spreadsheet supplied to DMS by December 31, 2015. Also, if the provider responded with different information regarding the acceptance of Medicaid patients, the spreadsheet will include the updated response by the provider.

CoventryCares is reaching out to the providers who are not providing appointment times to our members according to their contractual obligations. We are providing education to those respective providers regarding the access guidelines, including after hours requirements. A follow-up survey call will be made 30 days post the education to determine if the provider is

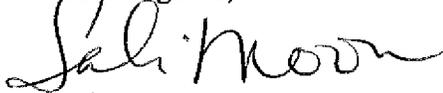
compliant with the timeframes. If the provider is not compliant, the Network Development department will be notified to extend official communication to the provider for compliance.

The following timeline will be followed:

- 1st outreach for provider education November 30, 2015
- 2nd access survey follow-up December 31, 2015
- Non-compliant provider correspondence January 31, 2016
- Updated spreadsheet with completion dates January 31, 2016

CoventryCares 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



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

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Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

Lisa D. Lee
Commissioner

December 17, 2015

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

RE: CC2016IPRO-1

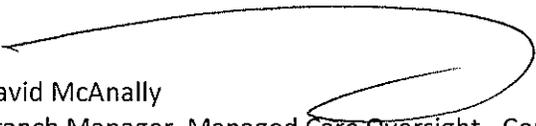
Dear Ms. Moore and Mr. Byrd,

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016IPRO-1 (29.1 Network Providers to be Enrolled and Section 29.7 Provider Program Capacity Demonstration) dated November 24, 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 Lee
Commissioner

November 20, 2015

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

RE: CC2016DPH-1

Dear Ms. Moore:

We are writing this Letter of Concern regarding recent payment errors with providers and the Kentucky Department of Public Health ("DPH") from your MCO.

Section 37.14 in your previous contract and Section 38.14 in your current contract states: The Contractor and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting.

Coventry failed to notify all of Kentucky's individual health departments of multiple and sundry recoupments related to third-party liability (TPL), retro-terminations, reprocessing of late fee schedule updates, and overpayments of VFC vaccines. Coventry was informed of the issues as early as 2013 and into the present. The underlying issue was because the 835 EOBs were not being broken out by individual health departments. Since that time, over 11,000 pages of EOBs in hard copy format have been sent to DPH for review. As recent as October 28, 2015, Department of Medicaid and DPH staff met with CoventryCares staff, Linda Steinke, and Sabrina Moore to discuss the issues.

In accordance with Contract Section 40.4(A), we are asking that CoventryCares notify us within two business days of receipt of this letter to reply with a plan that should include an explanation of why these incorrect payments are occurring, how they will be rectified so that they will not continue, and what preventive measures are being undertaken to ensure future compliance. We look forward to receiving WellCare'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



11/24/15

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 – CC2016DPH-1

Dear David McAnally:

Please accept this correspondence in response to your Letter of Concern regarding CoventryCares of Kentucky's (CoventryCares) recovery of Department of Public Health's payment errors.

Issue 1: Recovery Notification Not Issued to the Individual Health Departments:

Based upon the provider's set-up, the Master Vendor is set as the Kentucky Department of Public Health (DPH) for Tax ID 610-60-0439. Payments and recoveries are issued based upon the structure that the provider requested in 2011. As a result, the recovery notices are sent directly to the contracted entity vs. the individual health departments. This concern has been expressed by The Department of Public Health during operations meetings with the health plan, however, they were informed historically that individual recovery notices would not be able to go to individual health departments until they changed the structure of their set-up to allow CoventryCares to reimburse each individual health department separately. The DPH decided against the reimbursement of individual health departments. The health plan has proposed the following action steps to assist the provider with reconciling their current open payable concern:

- The 11,000 page collection remit has been placed on hold while the health plan works with the provider to supply a file that will assist them with reconciling their recoveries.
- The health plan has agreed to supply an excel file to the Health Department that will allow them to validate the open payable and identify which local health department owes additional payments back to the health plan.
- The Health Department has been informed during operations calls that the Health Plan is happy to supply them with the file elements needed for any recovery project to assist them with reconciliation.

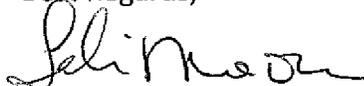
- The health plan has offered to coordinate a conference call with our 835 File subject matter expert to provide them with any additional support.

Issue 2: 835 Payment Recoupments

It was reported that the Department for Public Health was experiencing difficulty reading the PLB segments in the 835's Coventry returns. According to DPH, their system was not currently set up to accommodate for that. While they were in the process of changing their system they requested a file from the health plan. On 11/19/15, DPH reported that they identified the root cause of this concern on their end and the report request could be cancelled. Sharon reported that this was a result of an internal issue at DPH and not a result of something that CoventryCares of Kentucky did.

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

Division of Program Quality & Outcomes
275 E Main St. 6 C-C
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Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

Lisa D. Lee
Commissioner

December 17, 2015

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

RE: CC2016DPH-1

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016DPH-1 (Letter of Concern regarding payments to health departments) dated 11/24/15.

Please be advised that the response is accepted. If we may be of any additional assistance, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "David McAnally", with a long, sweeping underline.

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

December 7, 2016

Sabrina Moore
Terence L. Byrd
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016AV-1

Dear Ms. Moore and Mr. Byrd:

We are writing this Letter of Concern regarding a recent Avesis Bulletin dated September 10, 2015 (attached), RE: Change in Pre-Authorization Requirement for Nitrous Oxide (D9230) and Non-Intravenous Moderate (Conscious) Sedation (D9248)

In paragraphs two and three the Bulletin states:

For Members ages 10 to 14, a pre-authorization request for D9230 and/or D9248 must be submitted along with a narrative that describes the health issues. It will be approved under EPSDT if there are at least three (3) services provided on the same date of service from any of the following categories: space maintainers, restorative, endodontics or oral surgery. Only one (1) service per tooth is applied to the requirement; multiple services on a tooth count as a single service.

For Members ages 15 to 20, substantially more justification will be required for approval. Adult Members do not qualify for EPSDT.

As you are aware 4.3 Delegations of Authority states: The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor.

We are concerned this policy is a barrier to services for our members and we want to better understand how this policy meets the goals of the EPSDT benefit; therefore, the Department is requesting clarification from your MCO in the response.

We would like to know how many members have been denied by Avesis based upon this Bulletin (for ages 10 to 20). We would like to know how many members (if any) as identified in Section 36.1 Individuals with Special Health Care Needs (ISHCN) (for ages 10 to 20) have been denied.



In accordance with Contract Section 40.4(A), we are asking that Coventry notify us within two business days of receipt of this letter with a plan. This plan should include an explanation of why the information was not submitted timely and preventive measures to ensure future compliance with DMS requests. We look forward to receiving Coventry'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

Change in Pre-Authorization Requirements for D9230 and D9248

TO: Dentists and Dental Specialists for CoventryCares and WellCare
FROM: Dr. Jerry Caudill, Kentucky State Dental Director
DATE: September 10, 2015
RE: **Change in Pre-Authorization Requirement for Nitrous Oxide (D9230) and Non-Intravenous Moderate (Conscious) Sedation (D9248)**

Kentucky Medicaid members age 9 and younger will automatically be approved for one (1) unit of D9230 and/or D9248 per appointment under EPSDT – a pre-authorization is not required.

For Members ages 10 to 14, a pre-authorization request for D9230 and/or D9248 must be submitted along with a narrative that describes the health issues. It will be approved under EPSDT if there are at least three (3) services provided on the same date of service from any of the following categories: space maintainers, restorative, endodontics or oral surgery. Only one (1) service per tooth is applied to the requirement; multiple services on a tooth count as a single service.

For Members ages 15 to 20, substantially more justification will be required for approval. Adult Members do not qualify for EPSDT.

Remember to check the EPSDT box when submitting any claim that includes D9230 and/or D9248 or it will be denied as a non-covered service.

Members ages 10 to 20, identified with special needs or a medical condition, must have a letter from their physician documenting the medical condition. This letter will serve to waive restrictions for diagnostic and/or preventive services or the number of services rendered. Diagnostic and preventive services include exams, radiographs, prophylaxis, fluoride, and sealants.

For an emergency or an appointment scheduled on short notice, a post-treatment review of nitrous oxide and/or non-intravenous sedation must be requested. When filing the claim, be sure to include codes D9230/D9248 on the same ADA claim form as the services rendered or they will be denied. Also include documentation that explains the inability to obtain a pre-treatment estimate and the reasons for use of nitrous oxide/non-intravenous sedation.

We trust that these guidelines are clear and will be helpful. If you have questions or need additional clarification, please e-mail me at jcaudilldmd@avesis.com.

Thank you for your continued participation with the Avēsis Dental Provider Network in Kentucky.



12/14/15

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 – CC2016AV-1

Dear David McAnally:

Please accept this letter as a formal response to your Letter of Concern dated December 7, 2015, regarding the Avēsis Bulletin dated September 10, 2015 (copy attached).

The Letter requests information on how many members have been denied by Avēsis based upon the Bulletin (for ages 10-20). A total of 122 requests were denied based upon this Bulletin. That number, however, reflects the total number of denials. At least 17 denials were based upon incomplete clinical documentation or missing EPSDT indicators.

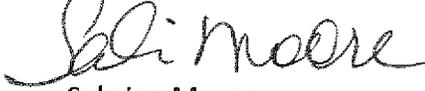
Furthermore, the Letter requests information on how many members (if any) as identified in Section 36.1 Individuals with Special Health Care Needs (ISHCN) (for ages 10–20) have been denied.

The information provided from Avesis indicates denials on 10 children listed as SSI child. Of the 10 denied, 3 were denied for insufficient information. Six children were listed as Foster care – all were denied because the number of services did not meet criteria.

These findings are being addressed with Avēsis. While CoventryCares of Kentucky agrees with Avēsis that nitrous oxide and non-intravenous moderate (conscious) sedation are examples of dental services that are useful, but not always required, we do not want to impose an undue administrative burden on providers requesting these services. We will work with Avēsis to assure that the ISHCN population is appropriately evaluated for these services when requested.

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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore

Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Division of Program Quality & Outcomes
275 E Main St. 6 C-C
Frankfort, KY 40621
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Fax: (502) 564-0223
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

Lisa D. Lee
Commissioner

January 8, 2016

Sabrina Moore
Terence L. Byrd
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016AV-1

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016AV-1	33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment	The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. <u>For additional information</u> see 907 KAR 11:034. Early and periodic screening, diagnosis, and treatment services and early and periodic screening, diagnosis, and treatment special services, Section 9 & CHFS Website: http://chfs.ky.gov/dms/epsdt+special+services.htm
	APPENDIX M. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)	EPSDT provides any Medically Necessary diagnosis and treatment for Members under the age of 21 indicated as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Kentucky Medicaid Program.

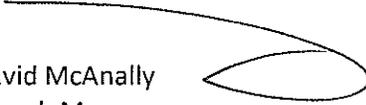


DMS is requesting that Coventry review the above referenced contract, Regulations, Cabinet for Health and Family Services (CHFS) website. DMS believes the response provided by Coventry in the Letter of Concern (LOC), issued by DMS on December 7, 2015, and the bulletin (attached) sent out by the subcontractor, Avesis, is a barrier to dental services for Medicaid members. This policy does not meet the goals of the EPSDT benefit.

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 Coventry'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
Catherine York, Office of Legal Services, Central Office Attorney
Cindy Arflack, Assistant Director, Division of Program Quality & Outcomes



1/26/16

Via Mail

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

Re: Request for Corrective Action Plan- CC2016AV-1

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated January 8, 2016 with regard to a request for a Corrective Action Plan for the following cited deficiency:

Identifying #	Contract Section	DEFICIENCY
CC2016AV-1	33.1 EPSDT	The Contractor shall provide all members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS.

As a background, the Avēsis’ State Dental Director, Dr. Jerry Caudill and the Avēsis Provider Relations Team identified that many dental offices were not aware that nitrous oxide (D9230) is a covered benefit for CoventryCares of Kentucky Medicaid children. In an attempt to educate the oral health community, Avēsis released the attached September 10, 2015 nitrous oxide bulletin after receiving approval from the health plan on August 10, 2015. In summary, the bulletin states the following:

- Kentucky Medicaid members age 9 and younger will automatically be approved for one (1) unit of D9230 and/or D9248 per appointment under EPSDT – a pre-authorization is not required.
- For Members ages 10 to 14, a pre-authorization request for D9230 and/or D9248 must be submitted along with a narrative that describes the health issues. It will be approved

under EPSDT if there are at least three (3) services provided on the same date of service from any of the following categories: space maintainers, restorative, endodontics or oral surgery. Only one (1) service per tooth is applied to the requirement; multiple services on a tooth count as a single service.

- For Members ages 15 to 20, substantially more justification will be required for approval. Adult Members do not qualify for EPSDT.

Avēsis understands that DMS interprets the Avēsis policy related to administration of nitrous oxide and oral sedation for Medicaid Children less than 20 years of age as a barrier to dental services covered under EPSDT.

In light of this perceived barrier, CoventryCares of Kentucky and Avēsis have made modifications to the policy as outlined below:

Avēsis has evaluated the approval process for the administration of Nitrous Oxide and Non-Intravenous (Conscious) Sedation, and have decided to apply the usual EPSDT requirements to substantiate medical necessity for these codes. In addition, all members up to age 20 with a documented intellectual disability will automatically qualify for approval of these procedures. Coverage of these procedures will also be approved when a licensed or certified health care professional indicates that the service is medically necessary for Members under the age of 21 even if the service is not otherwise covered by the Kentucky Medicaid Program.

Detail of Planned Actions for Resolution:

1. Provider Notification:

- a. Rescind Avēsis Bulletin dated September 10, 2015 about change in pre-authorization requirement for Nitrous Oxide (D9230) and Non-Intravenous Moderate (Conscious) Sedation (D9248).
- b. CoventryCares of Kentucky shall approve the attached new provider notification.
- c. Avēsis shall mail the approved notice to the provider network.
- d. The above actions shall be completed within 15 business days.

2. Utilization Management:

- a. Revise pre-service criteria to reflect approved changes regarding D9230 and D9248.
- b. Avēsis will train the Utilization Management Team and Kentucky Dental Consultants to apply the revised criteria.
- c. The above actions shall be completed with 15 business days.

3. CoventryCares of Kentucky Monitoring:

- a. Avēsis will provide a quarterly summary of the total number of pre-authorization requests for Nitrous Oxide (D9230) and Non-Intravenous Moderate (Conscious) Sedation (D9248) and a summary of the determinations (approved/denied).

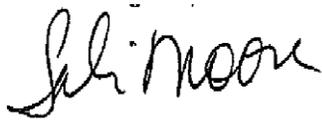
9900 Corporate Campus Drive • Suite 1000 • Louisville, KY 40223

502-719-8600 • 888-470-0550 • www.coventrycaresky.com

CoventryCares of Kentucky is a Medicaid product of Coventry Health and Life Insurance Company

CoventryCares 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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Division of Program Quality & Outcomes
275 E Main St, 6 C-C
Frankfort, KY 40621
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Fax: (502) 564-0223
www.chfs.ky.gov

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

Stephen P. Miller
Commissioner

February 9, 2016

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

RE: CC2016AV-1

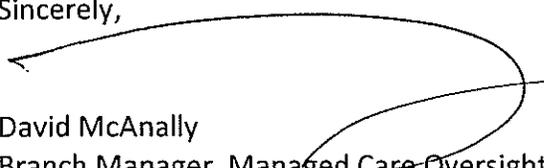
Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016AV-1 (33.1 EPSDT Early and Periodic Screening, Diagnosis and treatment and APPENDIX M. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)) dated February 2, 2016.

Please be advised that the response is accepted contingent upon Aetna's submission of Avesis' quarterly summaries. DMS would also like Aetna to include Stephanie Bates and the assigned DMS liaison on all submissions and/or correspondence.

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: Stephen P. Miller, 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
Director

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

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

RE: CC2016ENC-1

Dear Ms. Moore:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016ENC-1	16.1 Encounter Data Submission	The Contractor shall ensure that Encounter data is consistent with the terms of this Contract and all applicable state and federal laws. (See Appendix F. "Encounter Data Submissions Requirements and Quality Standards.") The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract.

In reviewing only the FQHCs and RHCs resubmissions for November, Coventry had a total of 126,768 days over thirty (30). Please ensure your response includes a reasonable timeframe to improve your resubmissions.

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 Coventry's Corrective Action Plan and will be available for your questions throughout the process.

Sincerely,

A handwritten signature in black ink, appearing to read "David McAnally". The signature is written in a cursive style with a long horizontal stroke that loops back to the left.

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



12/31/15

Via Mail

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

Re: Request for Corrective Action Plan- CC2016ENC-1

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated December 17, 2015 with regard to a request for a Corrective Action Plan for the following cited deficiency:

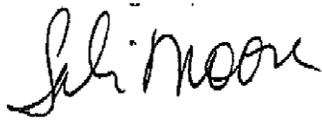
Identifying #	Contract Section	DEFICIENCY
CC2016ENC-1	16.1 Encounter Data Submission	The Contractor shall ensure the Encounter data is consistent with the terms of this Contract and all applicable state and federal laws.

Per your letter, CoventryCares of Kentucky failed to have a computer and data processing system sufficient to accurately produce data, reports and encounter files set in formats and timelines prescribed by the Department as defined in the contract. The Department reviewed FQHC and RHC resubmissions and found that CoventryCares of Kentucky has 126,768 days over thirty from the date of rejection.

The attached spreadsheet outlines how CoventryCares plans to address the encounter rejections.

CoventryCares 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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Division of Program Quality & Outcomes

275 E Main St, 6 C-C

Frankfort, KY 40621

Phone: (502) 564-9444

Fax: (502) 564-0223

www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

January 13, 2016

Sabrina Moore, Compliance Director
Terence L. Byrd, Executive Director
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016ENC-1

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016ENC-1 (Section 16.1 Encounter Data Submission) dated December 31, 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**

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Fax: (502) 564-0223
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 17, 2015

Sabrina Moore, Compliance Director
Terence L. Byrd, Executive Director
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016PN-2

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016PN-2	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.
National Provider Identifier (NPI)	Character	10	Must be submitted for providers required to have an NPI.
Medicaid Provider ID	Character	10	Provider ID assigned by Kentucky Medicaid. Must be submitted - if known.



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 504: 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: 12, maximum: 10)

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

Sincerely,

A handwritten signature in black ink, appearing to read 'David McAnally', with a long horizontal flourish extending to the left.

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



12/31/15

Via Mail

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

Re: Request for Corrective Action Plan- CC2016PN-2

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated December 17, 2015 with regard to a request for a Corrective Action Plan for the following cited deficiency:

Identifying #	Contract Section	DEFICIENCY
CC2016PN-2	Appendix D. MIS Requirement, Provider Subsystem B. Processing Requirements	The Provider Data Maintenance function must have the capabilities to: 1. Transmit a provider enrollment file to the Dept. in a specific format.

Per your letter, CoventryCares did not meet its contractual requirement by sending a file that caused HP to have an ABEND due to errors submitted. This was a result of an error received from our subcontractor Avesis.

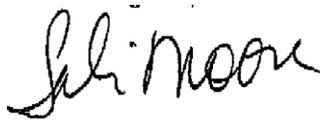
Avēsis’ Data Integrity Team identified solutions to resolve the ‘missing county code’ error and the ‘license error’ for Dr. Hurt’s provider record. The error’s occurred as a result of a misload of provider file information. Avēsis implemented an additional audit procedure to assure that future provider directories do not include inaccurate information. Please note, Avēsis released a new provider file on December 23, 2015.

Avēsis added an additional audit step prior to releasing the bi-weekly CoventryCares of Kentucky provider manual. In summary, three to four business days prior to the due date of the provider directory Avēsis’ Business Team will produce a ‘Preproduction’ CoventryCares of Kentucky Provider Directory. Avēsis’ Account Management Team will audit the directory to

confirm the data is correct in the provider directory. If a provider's file has to be updated, Account Management will forward a request for the revisions to Avēsis' Data Integrity Department. The revisions will be made within one (1) business day. After the revisions are made, Avēsis' Business Team will produce and release the 'CoventryCares of Kentucky' Provider Directory. Avēsis will continue to meet the delivery due dates for the directory.

CoventryCares 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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Division of Program Quality & Outcomes
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Frankfort, KY 40621
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Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

January 13, 2016

Sabrina Moore, Compliance Director
Terence L. Byrd, Executive Director
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016PN-2

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016PN-2 (APPENDIX D. MANAGEMENT INFORMATION SYSTEM REQUIREMENT, Provider Subsystem, B. Processing Requirements) dated December 31, 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,

A handwritten signature in black ink, appearing to read "David McAnally", with a long, sweeping horizontal stroke extending to the left.

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**

Matthew G. Bevin
Governor

Cindy Arflack
Director

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Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 21, 2015

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

RE: CC2016ENC-2

Dear Ms. Moore:

We are writing this Letter of Concern regarding a recent report given to us regarding your MCO's November Thresholds (attached). Coventry had a total of 4,983 threshold errors.

In accordance with Contract Section 40.4(A), we are asking that Coventry 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 Coventry'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





12/28/15

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 – CC2016ENC-2

Dear David McAnally:

This letter is in response to your Letter of Concern dated December 21, 2015 and a follow up letter that was dated December 18, 2015 because CoventryCares of Kentucky had 4,983 threshold errors. Based on a review of the report attached, it showed a total of 4,983 threshold errors; however, when the “3B-ENC-650-M” report for November 2015 was reviewed, it showed 8,654 threshold errors.

Below please find a summary of the preventive measures and timeframes that will be taken to assure future compliance:

- When certain provider related edits are received, the records are put through a mapping process to assure that the provider data is consistent with that on the KY Provider File.

This on-going process that applies to more than 80% of the rejected encounters. When the migration to the Aetna platform occurs in February 2016, the post-edit mapping will occur before the encounter file is submitted to DMS.

- Coventry is waiting for further direction from DMS on several edits (i.e. Edits 1955, 2502, 3601, 2602) and an estimated time of completion is not available.
- Certain rejected encounters cannot be corrected and therefore, the claim payment must be reversed. The recovery process takes 90+ days to resolve and once the payment is recovered, the rejected encounter remains on the inventory report since rejected encounters cannot be voided. Coventry is waiting for further direction from DMS on how to resolve the rejected encounter when recovery is pursued.

Attached to this letter is an Excel file that details for each of the MMIS Threshold Edit codes received in November the approach that will be taken to prevent each different edit and the timeframe. Many of these activities are on-going and a few require additional feedback from DMS and/or a fix by a vendor to be applied before corrections can be performed.

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,

A handwritten signature in black ink that reads "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Division of Program Quality & Outcomes
275 E Main St. 6 C-C
Frankfort, KY 40621
Phone: (502) 564-9444
Fax: (502) 564-0223
www.chfs.ky.gov

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson
Secretary

Cindy Arflack
Director

Veronica L. Judy-Cecil
Acting Commissioner

January 14, 2016

Sabrina Moore, Compliance Director
Terence L. Byrd, Executive Director
CoventryCares Health Plan
9900 Corporate Campus, Ste. 1000
Louisville, KY 40223

RE: CC2016ENC-2

Dear Ms. Moore and Mr. Byrd:

Please accept this correspondence as notification from the Commonwealth of Kentucky, Department for Medicaid Services ("Department") that Coventry Cares ("Coventry") is not in substantial compliance with certain material provisions of the Managed Care Contract ("Contract") between the Commonwealth of Kentucky and Coventry. Pursuant to Section 40.4 of the Contract, Coventry 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
CC2016ENC-2	16.1 Encounter Data Submission	The Contractor shall ensure that Encounter data is consistent with the terms of this Contract and all applicable state and federal laws. (See Appendix F. "Encounter Data Submissions Requirements and Quality Standards.") The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract.

Recently the Department issued a Letter of Concern on December 21st regarding your MCO's November Thresholds (Coventry had a total of 4,983 threshold errors).

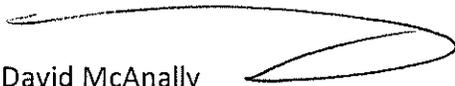
A clarification email was sent on Monday the 28th regarding the source of the information to Sabrina Moore, Coventry.

In reviewing the response (dated 12/28/15) it appears the expectation of Coventry is for DMS to direct your organization on how to solve their problem(s). Please note this response is unique to Coventry. Please also note, our expectation is your MCO would be able to submit encounters in accordance with the contract through the expertise of the staff within your organization (and our Department to offer support). This response has resulted in the Letter of Concern being elevated to a Corrective Action Plan.

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 not being accepted.

We look forward to receiving Coventry'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



1/26/16

Via Mail

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

Re: Request for Corrective Action Plan- CC2016ENC-2

Dear Mr. McAnally

Please accept this correspondence in response to your notification dated January 14, 2016 with regard to a request for a Corrective Action Plan for the following cited deficiency:

Identifying #	Contract Section	DEFICIENCY
CC2016ENC-2	16.1 Encounter Data Submission	The Contractor shall ensure the Encounter data is consistent with the terms of this Contract and all applicable state and federal laws.

CoventryCares of Kentucky is in the final stages of migrating to the Aetna model and systems. The “current state” processes used to generate encounters and make corrections will remain in place until January 31, 2016. Between today and the end of January, corrections will continue to be made to rejected encounters using a custom process designed to improve our acceptance rate. The final claims will be processed on the legacy IDX platform on January 25, 2016. Those claims will then be sent as encounters on February 1, 2016. A special process will be run on February 4, 2016 to assure that any void transactions sent on February 1, 2016 are then completed from the legacy IDX platform.

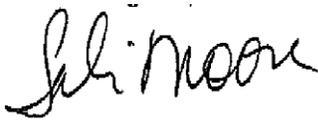
Additional work is also taking place on 2,000+ encounters that pertain to Medicare coordination of benefits (277 Status Edit 198/MMIS Threshold Edit 2205). A small test file was prepared on January 19, 2016 and sent to the “test region” of the DMS/HP encounter processing system. We appreciate the efforts that DMS and HP have taken to help resolve these erroneous rejects and we will be poised to submit corrections after testing is completed.

Starting on February 1, 2016, the “future state”, claims will be processed from the TriZetto QNXT platform. Additional front end claim edits have been developed which should reduce the number of encounters that need to be scrubbed or mapped. Claims will be extracted into encounter files using the TriZetto Encounter Data Management (EDM) software. Once the encounter files are created, they will then go through a series of scrubbing and mapping efforts to correct as many records before they are sent to DMS. Claims processed the week of February 1, 2016 will be sent to DMS on February 8, 2016.

When CoventryCares of Kentucky migrates to the Aetna claim and encounter platforms in February, we anticipate a reduction in the number of threshold errors that occur on a weekly basis. Work efforts will continue to resolve encounters that were rejected from the IDX platform.

CoventryCares 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,

A handwritten signature in black ink, appearing to read "Sabrina Moore". The signature is written in a cursive, flowing style.

Sabrina Moore
Plan Compliance Officer



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Matthew G. Bevin
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Secretary

Cindy Arflack
Director

Veronica L. Judy-Cecil
Acting Commissioner

February 5, 2016

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

RE: CC2016ENC-2

Dear Ms. Moore and Mr. Byrd:

The Division of Program Quality & Outcomes is in receipt of the response developed for CC2016ENC-2 (Section 16.1 Encounter Data Submission) dated January 26, 2016 and received via email on January 27, 2016.

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: 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