KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - Addressed in the 2014 QI Program Description: Summary, Policies and Procedures, QI Work Plan, and QI Committee Structure. The 2014 QI Program Description Summary describes the program goals and objectives, the national and local MCO- level program structure, the governance (Board of Directors (BOD), CEO and Executive Quality Improvement Committee (EQIC)), corporate and regional resources, behavioral health (BH) QI, the QI Work Plan, QI Evaluation, and the role of the EQRO. Coventry indicated that in 2014 and 2015, the QI Program has been transitioning to the Aetna structure. Changes in 2015 include: Increasing QM/UM Committee meeting frequency from quarterly to monthly. Transitioning oversight of the program from the EQIC to the Quality Management Oversight Committee (QMOC) Meetings will increase from quarterly to bi-monthly Adding an Appeals and Grievances Committee as a sub-committee of the Compliance Committee. Transitioning Delegation Oversight from the Provider Network Department to the Compliance Department.	Full	Includes review of MCO Report #84 QAPI Program Description Addressed in the 2015 Quality Management (QM) Program Description: Overview, Program, Goals, Objectives, Patient Safety, Prevention and Wellness, Structure, Committee Structure, Corporate and Regional Resources, and External Quality Programs and Committee Participation. The 2015 QM Program is comprised of the QM Program Description, Policies and Procedures, Annual QM Program Evaluation, Annual QM Work Plan, QM Activities, QM Committee Structure. The 2015 QI Program Description describes the oversight, goals and objectives, the corporate and committee structure, QM staff, corporate and regional resources, behavioral health (BH) QI, the QI Work Plan, QI Evaluation, and the role of the EQRO.	

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	Monitoring of quality of care for re-credentialing via the Aetna quality of care database. Changing meeting frequency of the Peer Review Committee to as needed. Implementation of the QI Program is demonstrated in the 2014 QI Work Plan quarterly updates and related documents (e.g., PIPs, meeting minutes), and in the 2013 QI Evaluation. **Recommendation for CoventryCares:** Coventry should consider adding a list of the specific QI activities that are conducted in order to fulfill the program goals and objectives to its QI Program Description.		Implementation of the QM Program is documented in the 2015 QM Work Plan and the 2014 Annual Evaluation. During 2015, the transition to Aetna continued.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full - Addressed in the 2014 QI Program Description, Goals on page 3; Objectives on pages 4-6; Corporate and Regional Resources and key performance indicators on pages 14-15. The 2014 QI Work Plan and quarterly updates outline the program activities. The EPSDT activities are incorporated into the QI Work Plan and addressed in the separate HEDIS/EPSDT/ Performance Measure Work Plan. The 2013 QI Evaluation describes the outcomes and results of the program activities.	Full	Addressed in the 2015 QM Program Description in the Goals (pages 6-7), Objectives (pages 7-9). Demonstrated in the 2015 QM Work Plan, the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2015, the 2015 Prevention and Wellness Program and the 2014 Annual Evaluation.	
The Contractor's QI structures and	Full - Addressed in the 2014 QI Program Description (entire	Full	Addressed in the 2015 QM Program	

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processes shall be planned, systematic and clearly defined.	document), and the 2014 QI Work Plan. Evidenced in the 2014 QI Work Plan quarterly updates and related documents (PIPs, meeting minutes, reports) and in the QI Evaluation.		Description Demonstrated in the 2015 QM Work Plan, the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2015, the 2015 Prevention and Wellness Program and the 2014 Annual Evaluation.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Full - Addressed in the 2014 QI Program Description, Goals on page 3; Objectives on pages 4-6; 2014 QI Work Plan on page 16; and QI Evaluation on page 17. External Quality Review activities are described on page 17 of the 2014 QI Program Description. Linkage is demonstrated in the 2014 QI Work Plan and updates and in the 2013 QI Evaluation. In 2014, IPRO suggested that Coventry include HEDIS Adolescent Well Care (AWC) and Frequency of Ongoing Prenatal Care (FOP) among the measures targeted for improvement since a large proportion of the membership is < age 21 or women of child-bearing age and the HEDIS 2013 rates presented an opportunity for improvement. The MCO addressed this through measuring and improving HEDIS and Healthy Kentuckians (HK) Performance Measures related to adolescents and pregnant women as evidenced in the 2014 HEDIS/Healthy Kentuckians/ EPSDT Work Plan.	Full	Addressed in the 2015 QM Program Description in the Goals (pages 6-7), Objectives (pages 7-9). Demonstrated in the 2015 QM Work Plan and the 2015 Prevention and Wellness Program under "Reason for Selection" "Topic" and "Objective" as well as the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2015.	

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The QAPI program shall be developed in collaboration with input from Members.	Minimal - The 2014 QI Program Description only briefly mentions the Quality and Member Access Committee (QMAC) under the sub-heading Ad Hoc sub-Workgroups and sub- Committees on page 14. The membership, roles, and responsibilities of the committee are not described. QMAC meeting minutes were provided. The minutes did not demonstrate that the 2014 QI Program Description, 2014 QI Work Plan, or 2013 QI Evaluation were provided or reviewed by the committee. Coventry did describe the QI activities (e.g., HEDIS) to the committee; however, no committee input was documented. It appears that the committee was less structured and less active than in the prior year. **Recommendation for CoventryCares:** Coventry should ensure that the QMAC is provided with the QI program documents for review and input and that the committee routinely has input into the ongoing QI activities. This should be documented in the minutes. **MCO Response:** QMAC meeting formats and agendas have been updated to include review and opportunity for feedback and input related to QI program documents and ongoing QI activities. This will be documented in the minutes.	Minimal	Addressed in the 2015 QM Program Description, page 9 (Item H), page 11 (bullet #7), and page 19 Quality Member Access Committee (QMAC). In 2015, Coventry developed a QMAC Charter, which delineates the responsibilities, membership, and meeting frequency. In 2015, there were 4 QMAC meetings, held in different regions with different attendees. For the most part, the meetings were informational. At one meeting, HEDIS and PIPs were explained and the Member Handbook and educational materials were provided for review. There was a presentation on the Plan's improvement initiatives. There was little participation/input by the attendees. During the interviews, Coventry described a new QMAC process for 2016. Meetings will be held via Webex at a central location and regional outreach staff will convene committee members at each site. In this way, representatives from all	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and

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			regions can attend each meeting, allowing for more continuity of membership. **Recommendation for CoventryCares of Kentucky** Coventry should proceed with the plan for the new QMAC structure, work to recruit consistent members and attendance, and ensure that the committee fulfills its stated responsibilities, including review and feedback on key QM documents and activities. In addition, Coventry should include the attendees' roles (plan member, community agency) with the name in the minutes. **Final Review Determination** No change in review determination.	Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Minimal - The QMAC meeting held on 3/9/2014 documented the greatest level of input from the committee members. Most often, the meeting content consisted of MCO staff providing information on Coventry programs and activities. This was useful information for the committee members, but did not directly afford the opportunity for input into the QI Program activities or for the QMAC to fulfill its required functions.	Minimal	As described above, the meetings were informative, but there was little feedback/input by the attendees and the committee did not fulfill its stated function of reviewing MCO documents. **Recommendation for**	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities;

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	Recommendation for CoventryCares: As noted above, Coventry should ensure that the QMAC is provided with the QI program documents for review and input and that the committee routinely has input into the ongoing QI activities. This should be documented in the minutes. **MCO Response:** QMAC meeting formats and agendas have been updated to include review and opportunity for feedback and input related to QI program documents and ongoing QI activities. This will be documented in the minutes.		**CoventryCares of Kentucky** Coventry should solicit member feedback and demonstrate how the member input is addressed. **Final Review Determination** No change in review determination.	as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA)	Full - Coventry achieved NCQA-accreditation with Accredited status for the period 8/21/2014-8/21/2017.	Full	Coventry has achieved NCQA Accreditation for the period 8/2014 - 8/2017.	

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accreditation for its Medicaid product line.				
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	Minimal - Accreditation documents provided for the onsite review included only the NCQA cover letter and accreditation certificate. During the onsite review, Coventry provided a copy of an email regarding the accreditation documentation that was sent to DMS; however, the specific report components/attachments included were not discernible. DMS has a record of receiving only the accreditation certificate. Coventry needs to provide the following reports from the NCQA Interactive Survey System (ISS) to DMS with each accreditation cycle: A copy of the complete survey report that includes: The scoring at the category, Standard, and element levels Status Summarized & Detailed Results Performance Performance Measures Must Pass Results NCQA Recommendations History. **Recommendation for CoventryCares:** Coventry should provide the documentation listed above to DMS as soon as possible and thereafter, for each accreditation survey and any interim	Full	Coventry has provided the accreditation documents for the current accreditation cycle (2014 – 2017). The next accreditation review will occur in 2017. It is recommended that when the accreditation is renewed, Coventry should provide the NCQA letter, certificate and the survey report/findings in a timely manner.	

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	updates. **MCO Response:** Coventry explained during the EQRO audit of communication errors when delivering the result of the NCQA audit via email to DMS. Email trail was provided that showed difficulties on DMS side in opening the documents. DMS was finally able to open the certificate. The final report was submitted to DMS and EQRO prior to the EQRO on site audit being concluded. HEDIS and CAHPS review was not included in this NCQA audit. Coventry will provide the documentation listed for each accreditation survey and any interim updates. At the next accreditation review in 2017, Coventry will include both standards and HEDIS/CAHPS performance review. **Final Review Determination:** No change in review determination. DMS confirmed that the accreditation report was not received in the review year, CY 2014. It was received in 3/2015, during the onsite review. The MCO needs to provide the accreditation documentation, as required by the contract, when the accreditation results are received. A copy of the complete survey report with all applicable elements.			

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	Upon the next review, IPRO will review the accreditation documentation submitted to DMS to ensure same.			
Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor.	Full - The 2014 QI Program Description was submitted in July 2014.	Full	Coventry submitted MCO Report #84 2015 QM Program Description to DMS in July 2015.	
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	Substantial - MHNet administers and manages BH services, including mental health and substance abuse treatment services. Addressed in the 2014 QI Program Description on page 16. The 2014 QI Work Plan references ensuring BH Access; review/approval of BH Clinical Practice Guidelines (CPGs); availability of BH services; and continuity and coordination of physical health (PH) and BH. The 2014 QI Program Description, Committee Structure, on page 10, indicates that a BH practitioner or doctorate-level BH practitioner serves as a member of the QM/UM Committee. Review of the committee meeting minutes revealed that several MHNet and Aetna BH staff persons are members, but a network BH practitioner is not listed among the members. Similarly, in the 2014 QI Program Description, Behavioral Health, on page 16, the description reads that a BH practitioner serves as a member of the EQIC, but the agendas and minutes do not	Substantial	Addressed in the 2015 QM Program Description on pages 6-7, III Goals, items J and O: ensuring collaboration with BH networks, improving continuity and coordination of care between BH and PCPs; pages 11-12, VII Prevention and Wellness: for members with severe mental illness; page 15, QM/UM Committee: participation of an actively practicing, participating BH practitioner; page 22, Behavioral Health QI. Note that although the QM Program Description indicates that a BH practitioner will participate in the QM/UM Committee, a review of the minutes showed that MHNet staff participated in the committee, but there was no network BH	**MCO Response** The Health Plan is continuing to work to recruit additional specialties to QMUM, including a network BH practitioner.

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	reflect this. Demonstrated in the 20014 HEDIS/HK/EPSDT Work Plan, which includes the MCO's activities related to HEDIS Antidepressant Medication Management (AMM); in the PIPs related to major depressive disorder (MDD), ADHD, and the State-collaborative PIP on use of antipsychotics for children and adolescents; and in Report #17 QI Work Plan quarterly updates. Integration of BH and PH care were discussed at the QM/UM meetings held on 2/20/2014 and 6/19/2014. At the April meeting, the committee reviewed the MHNet Annual Evaluation. The 2013 QI Evaluation notes that a workgroup, consisting of Coventry and MHNet staff members was established in 2012. The group implemented interventions for the MDD PIP. Assessment of BH quality was limited to information in the 2013 QI Evaluation since the MHNet Annual Evaluation was not provided. **Recommendation for CoventryCares:** Coventry should ensure that the BH practitioners listed in the committee descriptions are recruited to participate in the quality committees. **MCO Response:** Coventry is actively seeking and recruiting BH practitioners to participate in the quality committees. BH has been integrated in to health services. A full time BH practitioner has been staffed in the Health services department		practitioner. During the interview, Coventry stated that the Plan continues recruitment efforts and at present a MHNet BH clinician participates in the committee. Demonstrated in the 2015 QM Work Plan: page 4 – Access to BH practitioners, availability of BH practitioners, page 7 BH clinical guidelines, page 8 continuity and coordination of BH/PH, page 11 triage and referral for BH services, page 16 focus study: major depression, PIP: ADHD, pages 17 – 18, HEDIS/HK/EPSDT BH measures, as well as in the 2015 Prevention and Wellness Program and the HEDIS/HK/EPSDT/Foster Work Plan. Demonstrated in the 2014 MHNet Quality and Utilization Improvement Program Evaluation. **Recommendation for CoventryCares of Kentucky** Coventry should continue its efforts to recruit a BH practitioner for the QM/UM Committee.	

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	and participates in the quality committees. This practitioner is working with quality committees to recruit external practitioners for participation.		**Final Review Determination** No change in review determination.	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Full - Addressed in the 2014 QI Program Description, Goals on page 3 and Behavioral Health on page 16. The BH QI program is integrated into the MCO's QI program. Several MHNet staff persons are members of the EQIC and QM/UM committees and workgroups. Monitoring of BH services and PH outcomes is demonstrated in annual oversight audits; HEDIS reporting; review of the MHNet Annual Evaluation; and conducting PIPs and other quality initiatives related to BH conditions, which are documented in the committee meeting minutes. Assessment of BH quality was limited to information in the 2013 QI Evaluation since the MHNet Annual Evaluation was not provided.	Full	Addressed in the 2015 QM Program Description on pages 6-7, III Goals, items J and O: ensuring collaboration with BH networks, improving continuity and coordination of care between BH and PCPs; pages 11-12, VII Prevention and Wellness: for members with severe mental illness; page 15, QM/UM Committee: participation of an actively practicing, participating BH practitioner; page 22, Behavioral Health QI. Demonstrated in the 2015 QM Work Plan: page 4 – Access to BH practitioners, availability of BH practitioners, page 7 BH clinical guidelines, page 8 continuity and coordination of BH/PH, page 11 triage and referral for BH services, page 16 focus study: major depression, PIP: ADHD, pages 17 – 18, HEDIS/HK/EPSDT BH measures, as well as in the 2015 Prevention and Wellness Program and the	

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			HEDIS/HK/EPSDT/Foster Work Plan. Demonstrated in the 2014 MHNet Quality and Utilization Improvement Program Evaluation. Coventry is conducting several PIPs related to BH care, including: antidepressant medication management, use of antipsychotics for children and adolescents, and most recently, preventive health services for members with serious mental illness.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to	Substantial - The 2013 QI Evaluation contains a review of activities for the period January 1, 2013 to December 31, 2013 and was submitted to DMS as required. Key findings included: The top 2 diagnoses (by volume) for female members are supervision of other than normal pregnancy and routine infant or child check. The top 2 diagnoses (by volume) for male members are routine infant or child check and ADHD. All Customer Service metrics met goal except overall call quality	Full	Includes review of MCO Report #85 QI Plan & Evaluation Coventry submitted MCO Report #85 2014 Annual Evaluation in July 2015. Key accomplishments for 2014 included: achieving NCQA accreditation, conducting PIPs on both BH and PH topics, expanding the network of providers, implementing a member survey to assess the understanding of member materials,	

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meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.	(96.40% versus 98%) and Claims Paid within 30 Days (98.60% versus 99%) All Pharmacy Call metrics met or exceeded requirements. The NurseLine diverted 87% of callers seeking ED care. Appointment availability for OB 3rd trimester visits is in need of improvement. 36% of after-hours calls were not answered per requirements. GeoAccess standards were met for PCPs and specialists. CAHPS member satisfaction for Shared Decision-Making was below the national average for adult, child and CHIP members. CAHPS Rating of Health Plan was below the national average for adult and CHIP members. Appeal timeliness was between 92 – 100% and < 25% of decisions were overturned. Grievance turn-around time was consistently < 30 days. Some issues with improper routing were identified and corrected. Clinical guidelines were updated and incorporated into the CCM and DM programs Coventry reported HEDIS and HK Performance Measures for the		moving prior authorization functions to Kentucky and adding staff, training CMs for integration of BH and PH case management, reviewing and updating clinical practice guidelines, providing CM to members with Hepatitis C, improving CM communication with DCBS, conducting outreach to providers to improve contact information, conducting member outreach in need of preventive and EPSDT services, completing provider and member satisfaction surveys, and increasing provider and member communications via newsletters and website enhancements. Goals for 2015 included: improving access and availability by expanding the network and educating providers, and informing members about transportation services; improving collaboration, coordination and continuity of care between BH providers and PCPs; integrating PH and BH; increasing HRA response rate; enhancing CM and conducting more in-person CM contacts; reducing over utilization of the ED;	

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	first time in 2013. The following HEDIS measures benchmarked at or above the 75th percentile: ADV, AMM, CAP 12-24 months, CAP 25 months – 6 years, and PPC –Timeliness of Prenatal Care. The following HEDIS measures benchmarked at or below the 25th percentile: Adolescent Well Care, Cervical Cancer Screening, Childhood Immunization Status – Combo 2, Chlamydia Screening, Comprehensive Diabetes Care (5 numerators), Controlling High Blood Pressure, Lead Screening for Children, PPC – Postpartum Care Visits, Weight Assessment and Counseling for Children and Adolescents (all 3 numerators), Well Child Visits – 15 months, and Well Child Visits – Ages 3-6 Years. HK Performance Measures presenting opportunities for improvement included: Adult Counseling for Nutrition and Physical Activity; Adolescent Risk Screening;, Prenatal Screening and Counseling and Adolescent Well Care for the children with special health care needs (CSHCN) population. The PIPs were continued and PIP proposals for 2014 were submitted. Twenty-eight provider sites were audited for compliance with medical record keeping standards and only 1 site failed the assessment. Key aggregate findings showed opportunities related to documentation of BMI; documentation of current medications; reports reviewed and initialed; and recording immunization status.		improving care related to antipsychotic use for children and adolescents, diabetes, and ADHD; reducing inpatient readmissions; designing and implementing a prevention and wellness program; managing QOC/adverse events; increasing the receipt of EPSDT services; improving CAHPS scores; improve rates for HEDIS and Healthy Kentuckians measures; begin preparing for the 2017 NCQA accreditation review. Coventry also prepared an annual MHNet Quality and Utilization Improvement Program Evaluation for CY 2014.	

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	The top 3 quality referrals were related to surgical site infections, treatment plan issues, and delay in treatment or diagnosis. The number of referrals that resulted in a confirmed Quality of Care finding was not reported. Overall provider satisfaction was rated at 2.8 out of 5 points, < the goal of 3. Opportunities identified for 2014 by Coventry included: Improving access and availability of care: increase network providers; educate providers regarding availability standards and members about transportation options. Reduce over-utilization of the ED: continue the PIP in progress. The other actions described are not interventions and are limited to meetings, analysis and trending of data, and tracking over-utilizers. Major depression: increase member and provider awareness and monitor medication compliance. Specific interventions are not described. Investigate Quality of Care (QOC) referrals and Adverse Events (AE): improving the process and possible focus study. Continuity of Care/Hospital Readmissions: collaboration between QI and concurrent review staff and implementation of a PIP. ADHD: collaboration with MHNet to develop a PIP. EPSDT: increase member and provider knowledge and			

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	collaborate with high-volume pediatric practices. Provider and Member Satisfaction: Administer surveys to define goals. No specific areas of satisfaction to be targeted were identified and planned interventions were not described. HEDIS: evaluate 2014 rates to determine where to focus improvement efforts. Specific measures were not identified. **Recommendation for CoventryCares:** Based on the 2013 findings across HEDIS, the HK Performance Measures, medical record documentation assessment, access and availability surveys, quality of care referrals, and satisfaction surveys, Coventry should evaluate 2014 performance and focus efforts on the following, where needed: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents. Preventive services for children and adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and measurement and documentation of BMI/percentile and counseling for nutrition and physical activity. Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression. Care for members with diabetes.			

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	Cervical cancer and Chlamydia screening. Surgical site infections. After-hours telephone access. Overall provider satisfaction. Member satisfaction with shared decision-making and the health plan overall. Based on findings presented at the QMAC meetings, Coventry should address the availability of member materials in Spanish. Since the QMAC requested materials in Spanish, these should be made available routinely. **MCO Response:** Coventry will assess improvement/deficiencies between the 2013 and 2014 annual eval and focus HEDIS, EPSDT, Prevention and Wellness, QMAC, provider access and satisfaction efforts towards opportunities for improvement. Areas of concern to focus on: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents. Preventive services for children and adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and measurement and documentation of BMI/percentile and counseling for nutrition and physical activity.			

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression. Care for members with diabetes. Cervical cancer and Chlamydia screening. After-hours telephone access. Overall provider satisfaction. Member satisfaction with shared decision-making and the health plan overall. Coventry will assess the availability of member materials in Spanish and increase availability if deficiencies are noted.			
22.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information. The MCO has participated in all EQRO activities, providing documentation, data and medical records when necessary.	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. Coventry has provided documentation, medical records, and data as requested by IPRO.	
The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	Full - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information. The MCO has participated in all EQRO activities, providing documentation, data and medical records when necessary. The MCO fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation.	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. Coventry has cooperated with and participated in all EQRO activities, providing documentation, data and medical records as requested. Coventry facilitated the 2016 compliance review, submitting	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			documents, data, and records; having staff available for interviews; and providing follow-up documentation. DMS allows MCOs to meet some federal and state requirements through deeming, where appropriate.	
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information. The MCO fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation.	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. Coventry has cooperated with and participated in all EQRO activities, providing documentation, data and medical records as requested.	
The Contractor shall assist the Department and the EQRO in	Full - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N;	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	contains an action item to ensure all required activities are in place and to provide requested information. Coventry fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation. In addition, the MCO provided all necessary documentation for the 2014 Detailed technical Report production, and has provided documentation for the upcoming 2015 report.		and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. Coventry has fully cooperated with the2016 and has provided all records and data for EQRO activities, as requested. In addition, Coventry provided documentation for the 2015 Detailed Technical Report production.	
22.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The	Minimal - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review. For the prior compliance review, Coventry provided responses to the preliminary findings and the information was considered in making the final review determinations. Coventry submitted corrective action plans (CAPs) to DMS. DMS	Substantial	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review.	**MCO Response** Issues not resolved related to member input with the QMAC committee. We have implemented the following to address this deficiency: A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall:	reviewed and approved the CAPs. Coventry did not fully address all of the prior deficiencies. For the 2015 compliance review, there are multiple domains that include deficiencies that have not been resolved since the 2014 and/or the 2013 review. **MCO Response:** Coventry will address all prior deficiencies, and for the current review, ensure that all deficiencies are fully addressed and resolved within the contract-required time frame (6 months). A compliance review work plan will be created to ensure proper and timely follow up is addressed.		Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. For the 2015 compliance review, Coventry provided responses to the preliminary findings and submitted corrective action plans (CAPs) to DMS. DMS reviewed and approved the CAPs. Coventry made substantial progress in addressing the areas of minimal and non-compliance, although all issues are not 100% resolved. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry continue working to resolve all areas that are less than fully compliant. **Final Review Determination** No change in review determination.	Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - Addressed in the 2014 QI Program Description, on page 17, under External Quality Review. Coventry assigned dedicated Compliance staff to serve as the EQRO liaison. The staff provided follow-up documentation necessary for the onsite review.	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. Coventry has assigned dedicated Compliance staff to serve as the EQRO liaisons. The staff provided follow-up documentation necessary for the onsite review.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan;	Full - Addressed in the 2014 QI Work Plan, which indicates that the Quality Manager informs the EQIC Committee of EQRO findings and develops, implements and monitors a corrective action plan. Evidenced in the QI Work Plan which indicates that the prior compliance review report was shared with EQIC in May 21, 2014 and in the EQIC meeting minutes.	Full	Addressed in the 2015 QM Work Plan. Evidenced in the QMOC meeting minutes discussion of EQRO compliance review.	
C. Submit a corrective action plan in	Minimal - Addressed in the 2014 QI Program Description, on page	Full	Addressed in the 2015 QM Program	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification;	17, under External Quality Review. According to DMS, Coventry submitted corrective action plans (CAPs) for the majority of deficiencies but initially refused to submit a CAP for the Health Risk Assessment domain. DMS reviewed and approved the CAPs. Coventry did not fully address all of the prior deficiencies. For the 2015 compliance review, there are multiple domains that include deficiencies that have not been resolved since the 2014 and/or the 2013 review. **Recommendation for CoventryCares:** Coventry should ensure that all prior deficiencies are fully addressed, and for the current review, ensure that all deficiencies are fully addressed and resolved within the contract-required time frame (6 months). **MCO Response:** Coventry will address all prior deficiencies, and for the current review, ensure that all deficiencies are fully addressed and resolved within the contract-required time frame (6 months). A compliance review work plan will be created to ensure proper and timely follow up is addressed.		Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation. Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. As described previously, Coventry has made progress in addressing prior deficiencies.	
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate	Minimal - Addressed in the 2014 QI Program Description, on page 5, under Objectives, and on page 17. The 2014 QI Work Plan contains action item to ensure all required EQR activities are in place and to provide requested	Full	Addressed in the 2015 QM Program Description, on page 9, Goals, item N; and page 22, under XI. External Quality Programs and Committee Participation.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
progressive and measurable improvement during the term of this contract; and	information. Some of the 2013 and 2014 compliance review findings of Minimal and Non-Compliance for varied domains and a number of review elements have not been addressed and/or resolved. Additionally, some recommendations related to the PIPs have not been addressed by the MCO. The two Interim PIPs required a Corrective Action Plan (CAP) based on the scores achieved. A conference call with DMS, IPRO and MCO was held and the MCO submitted a CAP to DMS. **Recommendation for CoventryCares:** The MCO should include the specific compliance findings and corrective actions with the target completion date in the QI Work Plan to ensure that all findings are fully addressed. **MCO Response:** Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings to the work plan. Coventry will address all DMS and IPRO recommendations related to the compliance review and for the PIPs.		Addressed in policy and procedure QI-002 External Quality Review. Demonstrated in the 2015 QM Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. As described previously, Coventry has made progress in addressing prior deficiencies.	
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	Full - Coventry submitted its responses the prior review findings and the responses were considered when making the final review determinations.	Full	Coventry submitted responses to the 2015 review findings and the responses were considered in making the final review determinations.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Coventry worked to develop and implement corrective actions.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full - Addressed in the 2014 QI Program Description and 2014 QI Work Plan which includes a task for submission of the QI Work Plan to DMS annually and quarterly submissions of QI Work Plan updates. Evidenced in the 2014 QI Work Plan which states that the 2014 QI Work Plan was submitted July 2014. Evidenced in Coventry's submission of Report #17 each quarter in 2014.	Full	Includes review of MCO Report #17 QAPI Work Plan Evidenced in quarterly submission of MCO Report #17 2015 QM Work Plan, as well as the 2015 Prevention and Wellness Program and the HEDIS/HK/EPSDT/Foster Work Plan 2015.	
outlines the scope of activities and	Minimal - Addressed in the 2014 QI Work Plan includes required elements: the activities with rationale for selection and corresponding NCQA accreditation requirement; as well as objectives, responsible staff, benchmarks, due dates, status, and comments on project status. This element received a score of Minimal because the recommendation from the prior year was not addressed. **Recommendation for CoventryCares:** Coventry should include all action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings. **MCO Response:** Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific	Full	Addressed and demonstrated in the 2015 QM Work Plan, which includes the activities with reason for selection, NCQA accreditation requirement, topic, objective, responsible staff, goal/benchmark, start and due dates, status, date of completion, and comments on project status.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	corrective actions related to the compliance findings to the work plan.			
the goals,	Full - The 2014 QI Work Plan contains goals based on contract requirements, internal and industry standards, and Quality Compass percentiles	Full	Addressed and demonstrated in the 2015 QM Work Plan, that contains a column for goal/objective (where applicable).	
objectives, and	Full - The 2014 QI Work Plan contains objectives for each activity.	Full	Addressed and demonstrated in the 2015 QM Work Plan, that contains a column for goal/objective (where applicable).	
timelines for the QAPI program.	Full - The 2014 QI Work Plan includes start and due dates, a status column, and a location for comments.	Full	Addressed and demonstrated in the 2015 QM Work Plan, that contains columns for start date, date due, and completion date.	
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	Substantial - Addressed in the 2013 QI Evaluation which includes revised goals, objectives, and interventions for the coming year. Committee minutes provide evidence of tracking and trending quality improvement activities, survey results, grievances and appeals, performance measures, and adverse events. In the 2013 QI Evaluation, Coventry addresses interventions targeting HEDIS measures on pages 39-40. However, many of the actions described are focused on availability of data and data collection. For instance, educating providers on HEDIS	Full	Addressed in the2014 Annual Evaluation. Coventry reported the following goals for 2015: improving access and availability by expanding the network and educating providers, and informing members about transportation services; improving collaboration, coordination and continuity of care between BH providers and PCPs; integrating PH and BH; increasing HRA response	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	specifications, implementing HEDIS reporting, developing a supplemental database, and obtaining correct provider contact information for medical record retrieval. Opportunities identified for 2014 by Coventry included: Improving access and availability of care: increase network providers; educate providers regarding availability standards and members about transportation options. Reduce over-utilization of the ED: continue the PIP in progress. The other actions described are not interventions and are limited to meetings, analysis and trending of data, and tracking over-utilizers. Major depression: increase member and provider awareness and monitor medication compliance. Specific interventions are not described. Investigate Quality of Care (QOC) referrals and Adverse Events (AE): improving the process and possible focus study. Continuity of Care/Hospital Readmissions: collaboration between QI and concurrent review staff and implementation of a PIP. ADHD: collaboration with MHNet to develop a PIP. EPSDT: increase member and provider knowledge and collaborate with high-volume pediatric practices. Provider and Member Satisfaction: Administer surveys to define		rate; enhancing CM and conducting more in-person CM contacts; reducing over utilization of the ED; improving care related to antipsychotic use for children and adolescents, diabetes, and ADHD; reducing inpatient readmissions; designing and implementing a prevention and wellness program; managing QOC/adverse events; increasing the receipt of EPSDT services; improving CAHPS scores; improve rates for HEDIS and Healthy Kentuckians measures; begin preparing for the 2017 NCQA accreditation review. Demonstrated in committee meeting minutes and the 2015 QM Work Plan, that contains activities related to accreditation, HEDIS, HK performance measures, CAHPS, EQRO, PIPs, access/availability, QM department functions, grievances/appeals, among other topics.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	goals. No specific areas of satisfaction to be targeted were identified and planned interventions were not described. HEDIS: evaluate 2014 rates to determine where to focus improvement efforts. Specific measures were not identified. **Recommendation for CoventryCares:** Based on the 2013 findings across HEDIS, the HK Performance Measures, medical record documentation assessment, access and availability surveys, quality of care referrals, and satisfaction surveys, Coventry should consider focusing its efforts on the following: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents. Preventive services for children and adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and measurement and documentation of BMI/percentile and counseling for nutrition and physical activity. Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression. Care for members with diabetes. Cervical cancer and Chlamydia screening. Surgical site infections.			

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	After-hours telephone access. Overall provider satisfaction. Member satisfaction with shared decision-making and the health plan overall. Based on findings presented at the QMAC meetings, Coventry should address the availability of member materials in Spanish. Translated MCO Member materials are required when ≥ 10% of members speak a language other than English, or when requested by a member. Since the QMAC requested Spanish language materials, Coventry should make these routinely available. **Recommendation for CoventryCares:** In the QI Evaluation, the MCO should define the specific HEDIS, HK Performance Measures and CAHPS items that will be prioritized and targeted in next year. **MCO Response:** Coventry will include specific HEDIS, HK Performance Measures and CAHPS items that will be prioritized and targeted in next year on the annual eval and appropriate action/work plans.			
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI	Full - Addressed in the 2014 QI Program Description which states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the EQIC. The EQIC responsibilities include review and approval of the QI	Full	Addressed in the 2015 QM Program Description, Quality Assessment/Performance Improvement Plan (pages 3-4) that states the QI program in accountable	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program and annual QAPI work plan;	Program Description and QI Work Plans, including updates. Discussion and approval of the 2014 QI Work Plan and 2014 QI Program Description is evident in EQIC minutes.		to the Quality Management Oversight Committee (QMOC) and board of directors. Addressed in the QMOC charter and QM/UM Committee charter. Evidenced in QMOC and QM/UM Committee meeting minutes.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - The 2014 QI Program Description, on page 6, states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the MCO's CEO and to EQIC. The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates (on page 9). The MCO's Chief Medical Officer has overall responsibility and oversight of the QI Program (on page 8).	Full	Addressed in the 2015 QM Program Description, Quality Assessment/Performance Improvement Plan (pages 3-4) that states the QI program in accountable to the Quality Management Oversight Committee (QMOC) and board of directors; and direction and oversight is provided by the Chief Medical Officer and (pages 5-6) Quality Management Oversight Bodies. Addressed in the QMOC charter and QM/UM Committee charter. Evidenced in QMOC and QM/UM Committee meeting minutes.	
review of written reports from the designated entity on a periodic basis,	Full - Addressed In the EQIC Description which indicates that the EQIC reviews the QI Program Description, QI Work Plan and	Full	Demonstrated in the QMOC meeting minutes which describe review of the	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
which shall include a description of QAPI activities, progress on objectives, and improvements made;	updates, and the Annual QI Evaluation, and is responsible for monitoring delegated services and the activities of sub-committees. Evidenced in quarterly committee reports and monthly EQIC meeting minutes.		QM Program Description, QM Work Plan, Annual Evaluation, monthly QM updates and subcommittee reports. Also seen in QM/UM Committee meeting minutes, including review of routine reports (under/over utilization, UM, Annual Evaluation, CM audits, IRR audits).	
review on an annual basis of the QAPI program; and	Full - The 2014 QI Program Description, on page 6, states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the MCO's CEO and to EQIC. Addressed In the EQIC Description which indicates that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation. EQIC minutes demonstrate that the committee reviewed and approved the2013 Annual Evaluation, 2014 QI Program Description and 2014 QI Work Plan at its May 21, 2014 meeting.	Full	Addressed in the 2015 QM Program Description, Quality Assessment/Performance Improvement Plan (pages 3-4) that states the QI program in accountable to the Quality Management Oversight Committee (QMOC) and board of directors; and direction and oversight is provided by the Chief Medical Officer and (pages 5-6) Quality Management Oversight Bodies. Addressed in the QMOC charter and QM/UM Committee charter. Evidenced in QMOC and QM/UM Committee meeting minutes.	
modifications to the QAPI program on an ongoing basis to accommodate review	Minimal - Addressed in the 2014 QI Work Plan which is organized by rationale for selection, including accreditation requirement,	Full	Addressed in the 2014 Annual Evaluation, accomplishments and	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
findings and issues of concern within the organization.	contract requirement, or EQRO review findings, and includes a column for comments where descriptive updates are provided. Reference is made to the HEDIS/HK/ EPSDT Work Plan which contains more detailed information for those measures. Some findings of Minimal and Non-Compliance from the 2013 and 2014 for varied domains and elements reviews have still not been addressed and/or resolved. Additionally, some recommendations related to the PIPs have not been addressed by the MCO. A conference call with DMS, IPRO and MCO was held and the MCO submitted a CAP to DMS. **Recommendation for CoventryCares:** Coventry should include all action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings. Coventry should ensure that all DMS and IPRO recommendations related to the compliance review and for the PIPs are fully addressed. **MCO Response:** Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings to the work plan. Coventry will address all DMS and IPRO recommendations related to the compliance review and for the PIPs.		opportunities. Evidenced in the 2015 QM Work Plan, as well as the HEDIS/ HK/ EPSDT/ Foster Work Plan 2015, and the Prevention and Wellness Program 2015. As described previously, Coventry has made substantial progress in addressing prior deficiencies.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full - The 2014 QI Program Description states that the BOD of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program. The BOD delegates oversight and direction of the Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC). The EQIC implements, monitors and evaluates quality improvement initiatives and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings.	Full	Addressed in the 2015 QM Program Description, Quality Assessment/Performance Improvement Plan (pages 3-4) that states the QI program in accountable to the Quality Management Oversight Committee (QMOC) and board of directors. Addressed in the QMOC charter and QM/UM Committee charter. Evidenced in QMOC and QM/UM Committee meeting minutes.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Full - Addressed in the EQIC Description, which states that the EQIC is comprised of senior leadership staff across the organization participate in QI Program activities. These include the CEO and Medical Director, and the Health Services, Government Relations, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals departments. Evidenced in the EQIC meeting minutes, which document participation across the organization. Addressed in the QM/UM Committee description which indicates that the QM/UM Committee is a subcommittee of the EQIC that	Full	Addressed in the QMOC Charter, which lists the membership as the CEO, COO, CFO, CMO, Compliance Officer, Quality Director, Medical Director, Provider Relations Director, Health Services Director, BH Director, Medical Management Director, Pharmacy Director, Network Director, and Community Development Manager. Demonstrated in the committee meeting minutes/attendance.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	includes physician representation. The Coventry Medical Directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation. **Recommendation for CoventryCares:** Coventry should consider creating Committee Charters as addendums to the QI Program Description. The Charters should include: Overall Roles and Responsibilities Specific responsibilities Meeting frequency Quorum Members of the Committee Designate voting/non-voting members Reports Annual Goals			
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - Coventry provided monthly committee meeting minutes and Report #21 for the EQIC and QMUM committees. The minutes and Report #21 were submitted to DMS quarterly, as required.	Full	Addressed in the QMOC Charter, that states the committee will meet a minimum of 6 times a year, and more often, if necessary. Addressed in the QM/UM Committee Charter, that states the committee will meet monthly. Demonstrated in meeting minutes	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			submitted. There were 5 QMOC meetings as of October 2015. There were 11 QM/UM meetings as of November 2015.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	Full - Addressed in the EQIC Description, which indicates that provider and subcontractor QI activities are reported to the EQIC annually or more often. The EQIC is responsible for integration of activities related to providers as well delegation oversight. Evidenced in the QM/UM Committee meeting minutes which included examples of QI activities relevant to providers and subcontractors. Evidenced in Coventry's quarterly reports which indicate that the Compliance Committee oversees subcontractor relationships. The Delegation Oversight Committee reports to EQIC and monitors the performance of subcontractors. Communicated to subcontractors in Contract section Appendix B State-Specific Addendum – Kentucky.	Full	Addressed in the QMOC Charter: "The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network…and work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers." Communicated to providers and delegates in the respective contracts – Network Capitation Agreement, section 2.7 Quality Improvement Utilization Management; Ancillary Provider Agreement, item #16 QAPI Program & Attachment B-2 QI Activities. Communicated in the Provider Manual.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Evidenced in the QMOC minutes and QM/UM Committee minutes, discussion of and reports from the delegation oversight committee and in QM updates to the committee.	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Full - Addressed in the 2014 QI Program Description and 2014 UM Program Description which indicate that Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities as well as the committee descriptions. Evidenced in the EQIC meeting minutes, which document participation across the organization. Evidenced in the QM/UM minutes which identify membership from across the organization. Coventry also submitted a variety of quality program documents from CoventryCares of Nebraska, including Medicaid Medical Advisory Committee meeting agendas, minutes and reports and Quality Management Oversight Committee meeting agendas, minutes and reports. These appear to be examples of the Aetna Better Health process for QI oversight.	Full	Addressed in the 2015 QM Program Description and 2015 UM Program Description and the QMOC and QM/UM Committee Charters. Demonstrated in the QM/UM Committee minutes and QMOC minutes by participation from across the organization.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to,	Full - Addressed in the QI Program Description which reports that the BOD delegates responsibility for the quality improvement process to the EQIC and CEO. Coventry's Medical Director has overall responsibility for the QI Program and is an active member of the EQIC which is chaired by the MCO's CEO.	Full	Addressed in the 2015 QM Program Description. Staff resources include: clinical and professional staff, support from corporate and health plan staff including Medical	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
monitoring and evaluation of Member's care and services, including the care and services of Members with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	Addressed in the QI Program Description, C. National and Regional/Local Resources, pages 12 -14. Locally, the CMO and VP of Medical Affairs are responsible for directing the QI programs. Medical Directors are responsible for medical management programs. The Director of Health Services ensures staffing levels and staff competencies. Managers and supervisors oversee day-to-day activities. Local QI Program staff includes clinical and professional staff supported by Medical Directors and staff from the following departments: UM and QI, Network Management, Provider Relations, Compliance, IT support and Member Services. Analytic Resources encompass multiple experienced QI personnel, data analysts, certified coders, Information Systems and actuarial experts.		Directors, UM staff, Network Management staff, Provider Relations staff, Compliance staff, IT support and Member Services staff. Analytic resources include data analysts, certified coders, Information Systems experts and actuarial experts. During the interviews, Coventry described expansion of the staff that conduct member outreach for gaps in care, hiring and deploying an EPSDT coordinator, Prevention and Wellness leader, Community Outreach leader, and hiring more regional community outreach staff.	
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	Full - Addressed in the 2014 QI Work Plan, which includes a task for submission to DMS. Evidenced in the 2014 QI Work Plan which notes annual submission in July 2014 and in Report #84. Submission of quarterly updates is documented in Report #17, submitted quarterly to DMS as required.	Full	Coventry submitted MCO Report #85 QM Work Plan in July 2015. Coventry submitted MCO Report #17 QM Work Plan updates, quarterly in 2015.	
19.4 QAPI Monitoring and Evaluation				
The Contractor, through the QAPI	Full - Addressed in the 2014 QI Program Description, on page 2	Full	Includes review of MCO Report #23	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.	and in the Goals (page 3) and Objectives (pages 4-6). Evidenced in the 2013 QI Evaluation and quarterly Work Plan updates, Report #17. On page 69, the 2013 QI Evaluation indicates that all clinical, preventive and BH guidelines are reviewed on an annual basis and are posted on the Coventry web site and communicated to the provider network via fax blast. The 2013 QI Evaluation and quarterly reports show ongoing monitoring of quality of care and describe monitoring activities and results focused on special needs, conditions, and other populations. Evidenced in the QM/UM committee minutes which contain evidence of developing CPGs; setting performance improvement goals; conducting case management initiatives; overseeing progress of PIPs; reviewing utilization reports, grievances and appeals data, and nurse line protocols and reports. There is also evidence of monitoring quality of care concerns and sentinel events. Evidenced in the 2014 QI Work Plan which indicates that review of PH CPGs was completed in September 2014 and review of BH CPGs in April 2014. Evidenced in Report #23 Evidence Based Guidelines for Practitioners, which describes the guidelines used by the MCO and updates to guidelines completed each quarter, if any.		Evidence Based Guidelines for Practitioners Addressed in the QM Program Description under Quality Management Oversight Bodies (page 5), Objectives (page 8), Prevention and Wellness (page 12); QM/UM Committee (page 15). Addressed in policy and procedure QI-020 Preventive Health Guidelines Policy, QI-024 Clinical Practice Guidelines and Standards of Care Policy. Addressed in QM/UM Committee Charter. Evidenced in the 2015 QM Work Plan UM/QM Committee meeting minutes, and MCO Report #23 Evidence Based Guidelines for Practitioners. Demonstrated in the 2014 Annual Evaluation, Section F. Clinical Guidelines and Section G. Quality Indicators – HEDIS/HK.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - Addressed in the 2014 2QI Program Description, page 6 Objectives, pages 8-9 Health Plan Structure, and pages 10-11, QM/UM Committee. Coventry conducted measurement of CPG compliance and reported the results to the QM/UM Committee on May 15, 2014.	Full	Addressed in the QM Program Description under Objectives (page 8), Prevention and Wellness (page 12); QM/UM Committee (page 15). Evidenced in the 2015 QM Work Plan UM/QM Committee meeting minutes, and MCO Report #23 Evidence Based Guidelines for Practitioners. Demonstrated in the 2014 Annual Evaluation, Section F. Clinical Guidelines and Section G. Quality Indicators – HEDIS/HK.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - Addressed in the 2014 QI Program Description, pages 2-3 Program, page 3 Goals, and pages 4-6 Objectives. Evidenced in the 2014 QI Work Plan, the 2013 QI Evaluation, and the QM/UM and EQIC meeting minutes.	Full	Evidenced in the 2015 QM Work Plan, the 2014 Annual Evaluation, and the QMOC meeting minutes. Demonstrated in the HEDIS/HK/ EPSDT/Foster Work Plan 2015, Prevention and Wellness Program 2015, 2015 KY HEDIS Strategy document, 2015 CAHPS Analysis, 2015 HEDIS Barrier Analysis and Interventions.	
The effectiveness of corrective actions must be monitored until problem	Full - Addressed in the 2014 QI Program Description, pages 2-3 Program, page 3 Goals, and pages 4-6 Objectives.	Full	Evidenced in the 2015 QM Work Plan, the 2014 Annual Evaluation, and the	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Evidenced in the 2014 QI Work Plan, the 2013 QI Evaluation, and the QM/UM and EQIC meeting minutes. Evaluating the effectiveness of corrective actions and interventions is evidenced in tracking of indicators via monitoring HEDIS data, monitoring PIPs and performance measures and other methods.		QMOC meeting minutes. Demonstrated in the HEDIS/HK/EPSDT/Foster Work Plan 2015, Prevention and Wellness Program 2015, 2015 KY HEDIS Strategy document, 2015 CAHPS Analysis, 2015 HEDIS Barrier Analysis and Interventions.	
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - Addressed in the QI Program Description, pages 7-8 National Structure, pages 8-9 Health Plan Structure, and pages 9–14 Committee Structure. The MCO's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff. The QM/UM Committee, which reviews and analyzes clinical data, includes members representing pediatrics, internal medicine, hospital, BH, Case Management, Appeals, Health Services and Pharmacy.	Full	Addressed in the 2015 QM Program Description, Quality Management Oversight Bodies (page 5), Corporate Structure (pages 12-13), Health Plan Structure (pages 13-14), Committee Structure (pages 14-20), Corporate and Regional Resources (pages 20-22). Addressed in the QMOC and QM/UM Committee Charters. Demonstrated in the committee meeting minutes.	
The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement	Substantial - Addressed in Policy and Procedures QI-00 Performance Improvement Projects and the 2014 QI Work Plan, which includes the PIPs as a task. Evidenced in Coventry's submission of Report #90, Report #92	Full	Addressed in the 2015 QM Program Description, policy and procedure Procedures QI-005 Performance Improvement Projects and the 2015 QM Work Plan, which includes the	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
projects (PIPs) and assessment that relates to enrolled members.	and quarterly Report #19 Performance Improvement Projects. In 2014, one baseline report was submitted late (ADHD PIP – due 9/1/14, received 9/18/14) and one revised proposal was submitted late (Antipsychotic Use PIP- due 12/20/14, received 12/30/14). Coventry PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions and (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes. PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP is a statewide collaborative directed by DMS. **MCO Response:** Coventry will ensure all PIP reports are submitted in a timely manner to meet deadlines set by DMS.		PIPs. Evidenced in Coventry's submission of MCO Reports #90 PIP Proposals, MCO Reports #92 PIP Measurements in September 2015 and quarterly MCO Reports #19 Performance Improvement Projects. In 2015, Coventry submitted the following PIP proposal and Reports: Proposals: (2016 PIPs) Preventive Care for Members with Serious Mental Illness and Postpartum Depression Baseline Reports: (2015 PIPs) Use of Antipsychotics in Children and Adolescents and Care for Diabetes Interim Reports: (2014 PIPs) ADHD and Inpatient Readmissions Final Reports: (2013 PIPs) Major Depression and ED Utilization PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP and 2016 Preventive Care for Members with Serious Mental Illness are statewide collaborative directed by	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			DMS.	
The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full - Addressed in QI-024 Clinical Practice Guidelines Policy, May 2014, which outlines the adoption and assessment process and in the 2014 2QI Program Description, page 6 Objectives, pages 8-9 Health Plan Structure, and pages 10-11, QM/UM Committee. Evidenced in Report #23 Clinical Practice Guidelines, which is submitted to DMS quarterly. Communicated to providers via the Provider Manual which describes clinical guidelines and where to locate them on the MCO's website. Communicated to members in the Member Handbook which includes EPSDT guidelines and recommendations for routine testing/screening and cancer screenings. The member newsletters also advise members regarding guidelines/health recommendations.	Full	Addressed in policies and procedures QI-020 Preventive Health Guideline Policy and QI-024 Clinical Practice Guidelines Policy and in the 2015 QM Program Description and the QM/UM Committee Charter. Evidenced in Report #23 Clinical Practice Guidelines, which is submitted to DMS quarterly. Communicated to providers via the Provider Manual which describes clinical guidelines and where to locate them on the MCO's website, via fax blast, and via mailings and newsletters. Communicated to members in the Member Handbook which includes EPSDT guidelines and recommendations for routine testing/screening and cancer screenings, newsletters, mailings and at community events.	
Mental Health and Substance Abuse practice guidelines shall be submitted to	New Requirement	Substantial	Behavioral Health guidelines are addressed in the MHNet Provider	MHNet integrated with the health plan in 2/2015. BH guidelines were presented

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Department and DBHDID.			Quick Reference Guide (pages 7-8). **Recommendation for CoventryCares of Kentucky** Coventry should provide evidence that the MH/SA practice guidelines were submitted to DMS and DBHDID, such as an email or certified mail with date and addressee at DMS/DBHDID. **Final Review Determination** No change in review determination. Note that the MCO should include submission to DMS in its process and DMS will share the documentation with DBHDID, per current interagency policy.	at the QMUM in November and were sent via fax blast to providers in 12/2015. Notification to DMS and DBHDID will be added to our process.
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - Addressed in QI-024 Clinical Practice Guidelines Policy, May 2014, which outlines the adoption and assessment process. Evidenced in QM/UM meeting minutes.	Full	Addressed in policy and procedure QI-020 Preventive Health Guidelines Policy and QI-024 Clinical Practice Guidelines Policy, QM/UM Committee Charter. Coventry clinical practice guidelines are derived from the American Heart Association, American Medical Association, National Heart Lung and Blood Institute, American Psychiatric	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Association Adoption of guidelines is evidenced in the QM Work Plan and QM/UM Committee meeting minutes.	
consider the needs of Members;	Full - Addressed in Policy and Procedure QI 024 Clinical Practice Guidelines Policy May 2014 which states "The topics selected for clinical guidelines development will be related to areas determined to be high risk, high volume and or problem prone areas, with guidelines related to the disease management programs and behavioral health." Evidenced in the 2013 QI Evaluation which includes results of population analyses. These analyses provide a breakdown of member demographics, top 25 diagnoses and special needs categories.	Full	Coventry gathers data and conducts analyses to assess the characteristics and needs of the membership. Addressed in the 2015 QM Program Description. Evidenced in the 2014 Annual Evaluation (pages 4-18).	
developed or adopted in consultation with contracting health professionals, and	Full - Addressed in QI 024 Clinical Practice Guidelines Policy, May 2014, which states "When clinical practice guidelines are developed and additional physician input is needed, draft guidelines are sent to the appropriate medical director for review and recommendations. The guidelines will be shared with the Corporate Quality Improvement Committee (QIC) for final approval." Evidenced in the QM/UM meeting minutes which include discussion of clinical guidelines. Preventive health guidelines were approved by QM/UM as per	Full	Addressed in policy and procedure QI-024 Clinical Practice Guidelines Policy and QM/UM Committee Charter. Demonstrated in QM/UM Committee meeting minutes.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	report 7/30/13. MHNet reviews behavioral Health guidelines prior to EQIC approval.			
reviewed and updated periodically.	Full - Addressed in QI 024 Clinical Practice Guidelines Policy, May 2014, on page 2, which outlines the adoption and assessment process. It states that "CPG's are reviewed and approved biannually by Coventry's Medicaid Advisory Committee (MAC) and Corporate Quality Improvement Committee (QIC)." Evidenced in the QM/UM meeting minutes which include discussion of clinical guidelines. Additionally, Coventry submitted copies of the CPGs that were updated during 2014.	Full	Addressed in policy and procedure QI-024 Clinical Practice Guidelines Policy and QM/UM Committee Charter. Demonstrated in QM/UM Committee meeting minutes.	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	Minimal - For UM and covered services, this is addressed in the UM Program Description which states that the UM Program includes processes to ensure that approved clinical national guidelines such as InterQual are applied equitably throughout the MCO's provider network. UM evaluates medical necessity based upon evidence based medical guidelines and assures that providers are educated on current clinical criteria. With regard ensuring Inter-rater reliability, Report #23 indicates that the Health Services team has monitoring tools to measure the inter-rater reliability of clinical decision making for UM nurses and physicians.	Full	Addressed in the 2015 UM Program Description (page 37-38) and policy and procedure QI-031 Self-Management Tools. Demonstrated in the QM/UM committee meeting minutes and in UM IRR results/Utilization Decision Consistency and Accuracy. Coventry reported IRR results for 2012, 2013, and 2014. Results for 2015 pending. Testing was conducted in 12/2015.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Further, the report states that inter-rater reliability testing was completed in Q4 2014 and would be reported to the QI Committee in Q1 or Q2 2015. The MCO added that the reporting schedule was currently under review. The November 2014 EQIC minutes have an agenda item related to IRR, however, there are no details provided and the results are not appended to the minutes. The 2013 QI Evaluation references the UM Evaluation report which is available upon request. For provider practice, in the report, Performance Measurement of the Effectiveness of Disease Management and Adherence to Clinical Practice Guidelines and in the QM/UM meeting minutes that include reporting of the results to the committee. No documentation was found to address how member education materials are reviewed to ensure consistency with CPGs and no evidence that this had been done was provided. There was discussion of the Disease Management program and compliance with guidelines for asthma and diabetes in the report, Performance Measurement of the Effectiveness of Disease Management and Adherence to Clinical Practice Guidelines. **MCO Response:** UM IRR results will be appended to the QMOC minutes. Reporting scheduled has been revised for 2015.			

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Process to be developed for review of member education to ensure consistency with CPGs.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at health improvement for selected performance measures, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Substantial - Addressed in the 2014 QI Program Description, page 5 Objectives, G HEDIS. The HK measures are not specifically noted in the objectives, however, there is a statement regarding State public health goals. Also addressed in the 2014 QI Work Plan and the HEDIS/EPSDT/HK Work Plan. Evidenced in Report # 96 Coventry's 2014 reporting of Health Kentuckian (HK) Performance Measure rates and audited HEDIS rates for measurement year (MY) 2013 and Report #18 Monitoring Indicators, Benchmarks, and Outcomes. Evidenced in the 2014 HEDIS/ EPSDT/HK Work Plan which details the interventions and activities related to the measures. As described in element In the 2013 QI Evaluation, Coventry addresses interventions targeting HEDIS and HK measures. However, many of the actions described are focused on availability of data and data collection. For instance, educating providers on HEDIS specifications, implementing HEDIS reporting, developing a supplemental database, and obtaining correct provider contact information for medical record retrieval. Many of the interventions targeting members are passive, e.g., mailed information, newsletters, and reminder cards.	Full	Addressed in the 2015 QM Program Description, Goals (pages 6-7) and Data Sources (page 20). Also addressed in the 2015 QM Work Plan and the 2015 HEDIS/EPSDT/ HK/Foster Work Plan. Evidenced in MCO Report # 96 Audited HEDIS Data and submission of HK data, and in the 2015 HEDIS/ EPSDT/HK/Foster Work Plan, 2015 HEDIS Strategy document, 015 HEDIS Barriers and Interventions document and CAHPS Analysis document. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	More active interventions related to some of the measures included: Collaborating with a large practice to produce gap reports/physician performance profiles, some telephone outreach, hiring a dedicated EPSDT Coordinator, direct outreach to members and providers for those with lead levels > 5, 17P program for women at risk for preterm delivery, Maternal Postpartum Program, crib incentive program, participation in community events and initiatives, Likewise, most of the provider-targeted initiatives were mailings. Also, the success rate for outreach, the number of members reached, was not documented so it is not clear if the outreach efforts were effective. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. **Recommendation for CoventryCares:** Coventry should ensure that barrier analysis, based on data collection, is conducted and that a sufficient variety of active and targeted interventions are implemented for each PIP. **MCO Response:** Coventry will evaluate our processes to seek to ensure that barrier analysis, based on data collection, is conducted and that a sufficient variety of active and targeted interventions are implemented for each PIP. Additionally, our Prevention and Wellness program being			

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	developed in 2015 will work to provide more active and targeted interventions.			
Additionally, the Department, Contractor, and the EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	Not Applicable - To date, DMS has not chosen to rotate any measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	Not Applicable	To date, DMS has not chosen to rotate any measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	Not Applicable - DMS, IPRO and participating MCO(s) developed a set of performance measures specific to ISHCN. Coventry reports the ISHCN performance measures annually via submission of rates and data to the EQRO, IPRO for performance measure validation.	Not Applicable	DMS, IPRO and participating MCO(s) developed a set of performance measures specific to ISHCN. Coventry reports the ISHCN performance measures annually via submission of rates and data to the EQRO, IPRO for performance measure validation	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	Not Applicable - To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. Coventry reports the full performance measures annually via submission of Report #96 and reporting the rates and data to the	Not Applicable	To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	EQRO, IPRO for performance measure validation.			
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.	Not Applicable - To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. Coventry reports the full set of performance measures annually via Report #96 and submission of rates and data to the EQRO, IPRO for performance measure validation. Coventry submits Report #18 Monitoring Indicators, Benchmarks and Outcomes quarterly.	Not Applicable	To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. Coventry reports the full set of performance measures annually via MCO Report #96 Audited HEDIS Reports and submission of rates and data to the EQRO, IPRO for performance measure validation.	
20.3 Reporting HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit	Full - Addressed in the 2014 QI Work Plan, which includes tasks for DMS reporting. Coventry submitted Report #96 Audited HEDIS Reports to DMS as required, including the HEDIS Final Audit Report and a report of rates from the Interactive Data Submission System (IDSS).	Full	Includes review of MCO Report #96 Audited HEDIS Reports Addressed in the 2015 QM Work Plan, which includes tasks for DMS reporting. Coventry submitted MCO Report #96	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31st.			Audited HEDIS Reports to DMS as required.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.	Full - Evidenced in the 2013 QI Evaluation, which provides the graphs of 2013 and 2014 performance compared to Quality Compass benchmarks. The HEDIS Interactive Data Submission System (IDSS), included in Report #96, contains the required data, including, but not limited to, denominators, numerators and rates. The reporting template for the HK Performance Measures includes columns for denominator, numerator, and rate for each measure.	Full	Addressed in the 2015 QM Work Plan. Demonstrated in MCO Report #96 Audited HEDIS Results which contains the HEDIS IDSS and bar graphs, trends, and benchmarking for the HEDIS measures, stratified data, as well as Healthy Kentuckian measures.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Substantial - Addressed in the 2014 QI Work Plan Evidenced in Report #96 which contains an Excel file with the HEDIS data stratified by Medicaid eligibility category, race, ethnicity, gender and age. Note that only the numbers of compliant and non-compliant members for each sub-group are provided. The percentages are not provided. Numbers for some of the sub-groups are very small, so that limits the usefulness of the data. **Recommendation for CoventryCares:** Where feasible, Coventry should report the denominators, numerators and percentages for	Full	Addressed in the QM Work Plan. Demonstrated in MCO Report #96 Audited HEDIS Results which contains bar graphs, trends, and benchmarking for the HEDIS measures, stratified data, as well as Healthy Kentuckian measures.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the sub-groups and compare the rates with the total population rates to assess for significant differences and disparities. **MCO Response:** Coventry will assess its current process for stratification to determine if percentages can be provided.			
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	Not Applicable - To date, DMS has chosen not to define a subset of measures for evaluation. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	Not Applicable	To date, DMS has chosen not to define a subset of measures for evaluation. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	Not Applicable - To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	Not Applicable	To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data. The Performance Measure set is evaluated annually by DMS and the	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			EQRO, IPRO.	
20.4 Accreditation of Contractor by National Accrediting Body				
If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.	Minimal - Coventry Cares earned NCQA accreditation with a status of "Accredited" for the period 8/21/2014-8/21/2017. Note that the accreditation was a "standards only" assessment. Coventry had only reported one year of data, HEDIS 2013 and CAHPS 2013 at the time of the survey so including the performance on those measures would not have been appropriate. Accreditation documents provided for the onsite review included only the NCQA cover letter and accreditation certificate. During the onsite review, Coventry provided a copy of an email regarding the accreditation documentation that was sent to DMS; however, the specific report components/attachments included were not discernible. DMS has a record of receiving only the accreditation certificate. Coventry needs to provide the following reports from the NCQA Interactive Survey System (ISS) to DMS with each accreditation cycle: A copy of the complete survey report that includes: The scoring at the category, Standard, and element levels	Not Applicable	Coventry holds NCQA Accreditation for the period 8/2014 – 8/2017 and has provided the documentation to DMS. The next accreditation survey will occur in 2017.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Status Summarized & Detailed Results Performance Performance Measures Must Pass Results NCQA Recommendations History. **Recommendation for CoventryCares:** Coventry should provide the documentation listed above to DMS as soon as possible and thereafter, for each accreditation survey and any interim updates. At the next accreditation review in 2017, Coventry should include both standards and HEDIS/CAHPS performance review. **MCO Response:** Coventry explained during the EQRO audit of communication errors when delivering the result of the NCQA audit via email to DMS. Email trail was provided that showed difficulties on DMS side in opening the documents. DMS was finally able to open the certificate. The final report was submitted to DMS and EQRO prior to the EQRO on site audit being concluded. HEDIS and CAHPS review was not included in this NCQA audit. Coventry will provide the documentation listed for each accreditation survey and any interim updates. At the next accreditation review in 2017, Coventry will include			

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	both standards and HEDIS/CAHPS performance review. **Final Review Determination:** No change in review determination. DMS confirmed that the accreditation report was not received in the review year, CY 2014. It was received in 3/2015, during the onsite review. The MCO needs to provide the accreditation documentation, as required by the contract, when the accreditation results are received. A copy of the complete survey report with all applicable elements. Upon the next review, IPRO will review the accreditation documentation submitted to DMS to ensure same.			
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.	Full - Coventry Cares earned NCQA accreditation with a status of "Accredited" for the period 8/21/2014-8/21/2017.	Full	CoventryCares earned NCQA accreditation with a status of "Accredited" for the period 8/21/2014-8/21/2017. The next accreditation survey will occur in 2017.	
20.5 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the	Full - Addressed in Policy and Procedure QI-005 Performance	Full	Includes review of MCO Reports:	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.	Improvement Projects, this outlines the process, including types of projects (clinical and non-clinical), prioritizing topics to address the needs of members, interventions, and monitoring status. Evidenced in Report #90, Report #92, and Report #19. Coventry PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions and (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes. PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP is a statewide collaborative directed by DMS. The PIP topics were approved by the EQIC and the QM/UM committees, and then by DMS and the EQRO, IPRO as evidenced in the PIP attestations. Coventry's PIP proposals include appropriate rationales supported by MCO historical performance, relevance to the MCO's membership, and relevant state, national and Medicaid-specific data.		#19 PIPs #90 PIP Proposal #92 PIP Measurement Addressed in Policy and Procedure QI-005 Performance Improvement Projects. Evidenced in annual MCO Report #90 PIP Proposals, annual MCO Reports #92 PIP Measurements, and quarterly MCO Report #19 PIP updates. Coventry PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions, (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes, and (2016) Preventive Care for Members with Serious Mental Illness and Postpartum Depression. Coventry provided strong rationales for its MCO-chosen PIP topics, including literature citations, national statistics and data, and MCO-specific data. The BH topics for 2015 and 2016 are	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			statewide collaborative DMS-directed topics.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender	Full - Addressed in Policy and Procedure QI-005 Performance Improvement Projects, this outlines the process, including types of projects (clinical and non-clinical), prioritizing topics to address the needs of members, interventions, and monitoring status. Evidenced in Report #92 for the following PIPs, which includes baseline and interim results: 2013 Major Depression: interim 2013 Emergency Room Utilization: interim 2014 Reducing Readmissions: baseline 2014 ADHD: baseline (submitted late) Coventry also submits quarterly updates on its PIPs, Report #19.	Full	Addressed in Policy and Procedure QI-005 Performance Improvement Projects. Evidenced in MCO Report #92 PIP Measurements. Final measurements for the 2013 Major Depression and Emergency Room Utilization PIPs, interim measurements for the 2014 Reducing Readmissions and ADHD PIPs, and baseline measurements for the Antipsychotics and Diabetes PIPs. Coventry also submits quarterly updates on its PIPs, Report #19.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to Members and Providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Substantial - Addressed in Policy and Procedure QI-005 Performance Improvement Projects. The QI Program Description states that the health plan collaborates with participating providers and other relevant entities when necessary to meet program needs. It does not address collaborating with local health departments, behavioral health agencies and other community-based health/social agencies. Coventry collaborates with local Departments of Public Health in the 120 counties it serves via local outreach staff. Coventry is participating in the statewide collaborative with DMS, the other MCOs, and University of Louisville. The PIP reports and updates demonstrate collaboration across	Full	Addressed in Policy and Procedure QI-005 Performance Improvement Projects. Evidenced in MCO Report #92 PIP Measurements. Coventry also submits quarterly updates on its PIPs, Report #19. Coventry collaborates with local health departments, MHNet, Avesis, DCBS, participating facilities and providers, community agencies/events and other Medicaid MCOs for collaborative PIP topics.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the organization and with MHNet; working with providers is primarily via educational initiatives, and there is some collaboration with hospital EDs however collaboration with outside entities, such as local health departments, behavioral health agencies and other community based health/social agencies was not seen. Coventry does work with community agencies via the QMAC and participates in community events **Recommendation for CoventryCares:** Coventry should integrate collaboration with local health departments, behavioral health agencies and other community based health/social agencies in the PIP Interventions. **MCO Response:** Coventry is developing its Prevention and Wellness program for 2015 and will be inclusive of targeting partnerships with local health departments, behavioral health agencies and other community based health/social agencies. This collaboration will be updated in the PIPs as the objectives and activities are defined and implemented.		In the past year, there has been an increase in the MCOs engagement with the community.	
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.	Substantial - The QI Program Description states that the MCO will cooperate with DMS and the EQRO on improvements in services and clinical care concern and notes a commitment to quality and industry best practices. Use of encounter data-driven performance measures is not addressed. Evidenced in Coventry's participation in EQRO focused studies, encounter data validation, conducting PIPs, reporting HEDIS and	Substantial	Addressed in the 2015 QM Program Description, Program (page 2) and Annual Quality Management Evaluation and Work Plan (pages 4-5) and Goals (pages 6-7). Demonstrated in Coventry's participation in EQRO activities and	Please note the information requested from IPRO was added to our 2015 Program description and is listed on page 20, section X. Corporate and Regional Resources, the second bullet and the last bullet read as follows: ▪ Various internal reports capturing data from claims, encounter data,

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	HK Performance Measures, and submitting documentation and data when requested by DMS and/or the EQRO, IPRO. Encounter data is not sufficiently complete and accurate at this time; therefore, DMS and the MCOs cannot use the data for performance measure calculation. The EQRO is conducting encounter data validation and benchmarking studies to assess and improve data quality. **Recommendation for CoventryCares:** Coventry should add the use of encounter data-driven performance measures to its QI Program Description. **MCO Response:** Encounter data-driven performance measures will be added to the QI Program Description.		statewide collaborative PIPs. Encounter data is not sufficiently complete and accurate for use as the basis of performance measures: however, the EQRO continues to conduct data evaluation studies. **Recommendation for CoventryCares of Kentucky** Coventry should continue to work with DMS and the EQRO to improve the accuracy and completeness of encounter data in the Kentucky Medicaid MMIS. Final Review Determination No change in review determination. The MCO's documentation is fully compliant. The area that is less than fully compliant is that the encounter data is not sufficiently valid and reliable to be used to evaluate and monitor program performance. This applies to all participating MCOs. Coventry, like all MCOs, should continue to work	enrollment information, pre-authorization, appeals, complaints, case management, hospital logs, adverse/never events, readmissions, quality projects and initiatives, customer service calls, utilization data, inquiries ▪ Encounter data-driven performance measures for use on Performance Improvement Projects, HEDIS and Healthy Kentuckians performance Coventry participated in and responded to all inquiries related to focused studies, encounter data validation, conducting PIPs, reporting HEDIS and HK Performance Measures, and submitting documentation and data when requested by DMS and/or the EQRO, IPRO.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			with DMS to improve the quality of encounter data .	
The Contractor shall monitor and evaluate the quality of care and services by initiating at least one PIP each year and participating in one collaborative PIP each year. The Contractor-specific PIP shall alternate each year of the contract between one relating to physical health and one relating to behavioral health. The first collaborative PIP under this Contract shall have two components addressing both the physical and behavioral health of adults with Severe Mental Illness. The Department shall give the Contractor sixty (60) days' notice for subsequent collaborative PIPs under this Contract. The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. However, the Contractor may propose	Substantial - Addressed in Policy and Procedure QI-005 Performance Improvement Projects. In 2014, Coventry has submitted PIP reports, including two PIP proposals, 2 baseline reports and 2 interim measurement reports as evidenced in Report #90 and Report #92. In 2014, one baseline report was submitted late (ADHD PIP) and one revised proposal was submitted late (Antipsychotic Use PIP). The PIPs include on behavioral health and one physical health topic for each year. The 2015 Use of Antipsychotics for Children and Adolescents is the first statewide collaborative PIP. Coventry is participating in the collaborative and submitted a PIP proposal. DMS has not directed Coventry to conduct an additional PIP. **Recommendation for CoventryCares:** Coventry should ensure that all PIP reports are submitted timely. **MCO Response:** All reports will be submitted in a timely manner according to the due dates outlined in the contract.	Full	Addressed in Policy and Procedure QI-005 Performance Improvement Projects. In 2015, Coventry submitted MCO Report #90 PIP Proposals and MCO Reports #92 PIP Measurements which encompassed 2 baseline measurement reports, 2 interim measurement reports and 2 final measurement reports. Coventry submitted revised PIP proposals, as required. The PIP topics include one behavioral health and one physical health topic for each year. DMS has not directed Coventry to conduct an additional PIP.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department shall require Contractor to (i) implement an additional PIP specific to the Contractor, if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.				
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - Evidenced in Report #90 and Report #92 for the PIP in progress. Coventry used the required templates for its proposals, baseline reports and interim reports.	Full	Evidenced in annual MCO Reports #90 PIP Proposals and MCO Report #92 PIP Measurements and quarterly in MCO Reports #19 PIPs in progress. Coventry used the required templates for its proposals, baseline reports and interim reports.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Topic and its importance to enrolled members;	Substantial - Topic relevance was well supported and appropriate for five of the six PIP proposals. IPRO recommendations related to PIP rationale are listed below. Coventry did not address the recommendation. ADHD: The health condition is described, but not the intended means for improvement by "Offering enhanced and comprehensive services to children with ADHD". As mentioned in the 2013/2014 proposal comments (dated 1/8/2014), the topic should clearly be specified by including both the health condition and the focus on improving treatment for this condition. **Recommendation for CoventryCares:** Coventry should ensure that all PIP recommendations are addressed or resolved. The MCO has submitted a CAP DMS related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. The topic will be clearly specified by including both the health condition and the focus on improving treatment for this condition. The MCO has submitted a CAP related to its PIPs to DMS.	Full	The topic relevance for Coventry's PIPs was well supported. Coventry addressed prior and current EQRO and DMS recommendations.	
B. Methodology for topic selection;	Substantial - The rationale for each of the PIPs included national, statewide and plan-specific data to justify topic selection.	Full	The rationale for each of the PIPs included national, statewide and	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	IPRO recommendations related to PIP rationale are listed below. Coventry did not address the recommendation. ADHD PIP: The rationale does not present coherent and consistent performance improvement topic and performance measures in accordance with the recommendations made in the proposal review, dated 1/8/2014. **Recommendation for CoventryCares:** Coventry should ensure that all PIP recommendations are fully addressed or resolved. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. Rationale will be more clearly defined in all future reporting. The MCO has submitted a CAP related to its PIPs to DMS.		plan-specific data as well as literature citations to justify topic selection. Coventry addressed prior and current EQRO and DMS recommendations.	
C. Goals;	Minimal - Goals/targets for improvement are included in each of the PIP proposals. IPRO recommendations are listed below. Diabetes Care: Clarify whether the goal is to improve 4% from baseline or 4 percentage points from the baseline rate. Preventing Readmissions: The targeted improvement is stated as	Full	Goals/targets for improvement are included in each of the PIP proposals for each indicator. Goals are based on the NCQA guidelines for meaningful improvement. Coventry addressed prior and current EQRO and DMS recommendations.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	a 2 percentage point improvement. The Plan needs to provide a specific rationale for this goal. ADHD PIP: CoventryCares should quantify goals for each indicator based upon improving past performance and or achieving established benchmarks. This requirement scored Minimal due to the deficiencies related to PIP goals and the MCO did not address the PIP recommendations. **Recommendation for CoventryCares:** Coventry should provide goals with appropriate rationale for each PIP/indicator. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. Goals and/or targeted improvement will be more clearly defined in all future reporting. The MCO has submitted a CAP related to its PIPs to DMS.			
D. Data sources/collection;	Minimal - Data sources and collection procedures were described in each of the four PIP proposals. The IPRO evaluation and comments regarding indicators and	Full	Data sources and collection procedures were described in each of the four PIP proposals.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	methodology are described below. Preventing Readmissions: critical recommendations were not addressed. ADHD: critical recommendations were not addressed. Depression: Indicators and methodology were scored partially met. ED Utilization: Indicators and methodology were scored partially met. This requirement scored Minimal because the MCO did not address the PIP recommendations. **Recommendation for CoventryCares:** Coventry should review the prior PIP recommendations and address or resolve them. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. Critical recommendations, indicators and methodology will be addressed and included in all future reporting. The MCO has submitted a CAP related to its PIPs to DMS.		Many of the measures follow HEDIS specifications for data sources and methodology. Coventry addressed prior and current EQRO and DMS recommendations.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Intervention(s) – not required for projects to establish baseline; and	Minimal - Interventions were described in the PIP proposals and reports. The IPRO evaluation and comments regarding interventions are described below. Diabetes: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed. Preventing Readmissions: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed. ADHD: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed. Depression: Interventions were scored partially met. ED Utilization: Interventions were scored partially met. This element scored minimal because the MCO did not fully address the PIP recommendations. **Recommendation for CoventryCares:** Coventry should review the PIP recommendations and addressed them where necessary. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.	Full	Interventions were described in the PIP proposals and reports. Coventry modified its intervention strategies to include more active interventions.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Barrier analysis and interventions will be addressed and included in all future reporting. The MCO has submitted a CAP related to its PIPs to DMS.			
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	Minimal - Baseline results were reported for two PIPs and interim results were reported for two PIPs. The IPRO evaluation and comments regarding results reported are described below. Preventing Readmissions: The Results section should not include narrative related to other parts of the PIP. The MCO should modify the table in Appendix A for this specific PIP and put the table in the Results section. The Results section should include a table with eligible population(s), denominator(s), numerator(s), rate(s) and goal(s) with the performance indicator name(s) and measurement timeframe defined in the title and column headings. The proposal described stratifying the performance indicator results; no stratification of the measures is presented. In the Results section, the MCO reported on contacts to members who had been discharged. This process measure needs to be linked to a specific intervention and reported in a table for process measures in the Results section. ADHD: No baseline results were provided. Only with results of process measures for mailings are provided. The results for MY 2013/RY 2014 should be reported. If Coventry adopts the indicators suggested by IPRO, data for MY 2013 can be reported.	Full	This is only applicable for interim and final PIP reports. Coventry modified its presentation of results and modified the intervention strategies. Coventry's scores for the final and interim PIP reports improved from the prior year, and met requirements for all but one PIP. For the ADHD PIP, Coventry revised the measurement periods without receiving DMS approval.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The MCO should provide a table with the indicator(s) and the baseline eligible population(s), denominator(s), numerator(s), baseline rate(s) and benchmark rate(s) for each indicator. The process measures should include some measure of effectiveness of the interventions. Depression: Presentation of results clearly was scored not met. Comments and recommendations related to lack of clarity in the format used for reporting and the results presented; baseline data was not reported in the Results section; data for the final measurement should not be reported in the interim report; the benchmark needs to be clarified; clarifying the goal for the MPR measure; presentation of results as percentages; the figures need to be revised (data to be included, e.g., denominators); wording to use when reporting on improvement; interpretation of results; and suggestions on how to drill down into the data to inform interventions. ED Utilization: Presentation of results clearly was scored not met. Comments and recommendations related to lack of clarity in the format used for reporting and the results presented and were very similar to the comments for the Depression PIP. **Recommendation for CoventryCares:** Coventry should address the PIP recommendations. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior			

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. Baseline results, tables, narrative and formatting will be updated to meet EQRO recommendations. The MCO has submitted a CAP related to its PIPs to DMS.			
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Not Applicable - No final remeasurement reports are due; however, all PIPs address member confidentiality.	Full	This is applicable only to final PIP reports. Coventry met this requirement for both final PIP reports.	
B. Did Members participate in the performance improvement project;	Not Applicable - No final remeasurement reports are due; however, member interventions are addressed in all PIPs.	Full	This is applicable only to final PIP reports. Coventry met this requirement for both final PIP reports.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Not Applicable - No final remeasurement reports are due: therefore, financial impact cannot be assessed or reported.	Full	This is applicable only to final PIP reports. Coventry met this requirement for both final PIP reports.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	Not Applicable - No final remeasurement reports are due; therefore, dissemination of results and conclusions to members, providers, and others cannot be assessed.	Full	This is applicable only to final PIP reports. Coventry met this requirement for both final PIP reports.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Is there an executive summary;	Not Applicable - No final remeasurement reports are due; therefore, it is not possible for Coventry to provide an Executive Summary.	Full	This is applicable only to final PIP reports. Coventry met this requirement for both final PIP reports.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	Not Applicable - No final remeasurement reports are due; however, presentation of results for baseline and interim measurements is discussed under element 20.4 Performance Improvement Projects. The Contractor must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn, requirement F.	Full	This is applicable only to interim and final PIP reports. Coventry met this requirement for both interim and both final PIP reports.	
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	Minimal - The IPRO evaluation and comments regarding indicators and methodology are described below. Preventing Readmissions: critical recommendations were not addressed. ADHD: critical recommendations were not addressed. Depression: Indicators and methodology were scored partially met. ED Utilization: Indicators and methodology were scored partially met. The IPRO evaluation and comments regarding performance goals are described below: Diabetes Care: Clarify whether the goal is to improve 4% from	Full	Demonstrated in MCO Reports #90 PIP Proposals and MCO Reports #92 PIP Measurements. Coventry addressed the EQRO and DMS recommendations. Coventry met the requirements for quality indicators. Some quality indicators were based on HEDIS.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	baseline or 4 percentage points from the baseline rate. Preventing Readmissions: The targeted improvement is stated as a 2 percentage point improvement. The Plan needs to provide a specific rationale for this goal. ADHD PIP: CoventryCares should quantify goals for each indicator based upon improving past performance and or achieving established benchmarks. **Recommendation for CoventryCares:** Coventry should review the prior recommendations and addressed them where necessary. The MCO has submitted a CAP related to its PIPs to DMS. **MCO Response:** Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. The MCO has submitted a CAP related to its PIPs to DMS.			
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	Not Applicable - No final remeasurement reports are due; therefore, sustained improvement cannot be evaluated.	Full	Coventry submitted final remeasurement reports for 2 PIPs: Major Depression and ED Utilization. The MCO achieved some improvement for both PIPs.	
A. Project Proposal – due September 1	Minimal - Coventry submitted its project proposals timely.	Full	Coventry submitted MCO Reports	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Revisions to one proposal were submitted late (Antipsychotic Use PIP – due 12/20/15, received 12/30/15). **Recommendation for CoventryCares:** Coventry should ensure that revised proposals are submitted timely. **MCO Response:** All revised proposals will be submitted timely based on the timeline outlined by DMS and/or IPRO.		#90 timely.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Minimal - Coventry submitted one baseline report late in 2014 (ADHD PIP – due 9/1/14, received 9/18/14). **Recommendation for CoventryCares:** Coventry should ensure that all PIP reports are submitted timely. **MCO Response:** All reports will be submitted in a timely manner according to the due dates outlined in the contract.	Full	Coventry submitted MCO Reports #92 PIP Measurements timely.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	Full - Coventry submitted the interim reports timely.	Full	Coventry submitted MCO Reports #92 PIP Measurements timely.	
D. Conclusion – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	Not Applicable - No final remeasurement reports are due.	Full	Coventry submitted MCO Reports #92 PIP Measurements timely.	
20.6 Quality and Member Access Committee				

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Minimal - The QMAC is not addressed in the 2014 QI Program Description with the other committee descriptions. Report #21 states that there are four regional groups: South-West (Regions 1, 2 & 4), North Central (Region 31), North East (Regions 5 & 6), and East (Regions 7 & 8) and the purpose of the committee is to interact with members and get their feedback on topics such as quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the Plan. Report #21 for Q1 – Q4 2014 demonstrates that there were 6 QMAC Meetings during 2014. Coventry held QMAC meetings in several venues each quarter. In Q1, there were 4 meetings in Region 31, Regions 1 & 2, Regions 5 & 6 and Regions 7 & 8. In Q2 there was 1 meeting in Region 31. In Q3 there was 1 meeting comprised of Regions 1, 2, & 4. In Q4, no meetings were held. The content of the meetings was not consistent and in some cases, was very limited. There did not appear to be a standing committee membership, rather, varied members and advocates and community groups attended. **Recommendation for CoventryCares:** Coventry should include the QMAC as a regular committee in its QI Program Description, including the members, roles, responsibilities and meeting frequency.	Minimal	Includes review of MCO Report #21 MCO Committee Activity Addressed in the 2015 QM Program Description, page 9 (Item H), page 11 (bullet #7), and page 19 Quality Member Access Committee (QMAC). In 2015, Coventry developed a QMAC Charter, which delineates the responsibilities, membership, and meeting frequency. In 2015, there were 4 QMAC meetings, held in different regions with different attendees. For the most part, the meetings were informational. At one meeting, HEDIS and PIPs were explained and the Member Handbook and educational materials were provided for review. There was a presentation on the Plan's improvement initiatives. There was little participation/input by the attendees. During the interviews, Coventry described a new QMAC process for 2016. Meetings will be held via Webex at a central location and	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The QMAC responsibilities should include review of the QI Program Description, QI Work Plan, QI Evaluation, member materials and all materials required by the contract. The QMAC should have a standing membership comprised of community advocates and members for consistency. Others can be invited to participate as guests. **MCO Response:** QMAC has been added as a regular committee in the 2015 QI Program Description, including the members, roles, responsibilities and meeting frequency. Documentation of member recruitment efforts will be maintained and discussed during the committee update at the QMOC meetings.		regional outreach staff will convene committee members at each site. In this way, representatives from all regions can attend each meeting, allowing for more continuity of membership. **Recommendation for CoventryCares of Kentucky** Coventry should proceed with the plan for the new QMAC structure, work to recruit consistent members and attendance, and ensure that the committee fulfills its stated responsibilities, including review and feedback on key QM documents and activities. In addition, Coventry should include the attendees' roles (plan member, community agency) with the name in the minutes. **Final Review Determination** No change in review determination.	Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of	Full - Report #21 indicates that the QMAC meets quarterly and the committee is comprised of members and consumer advocates who represent the interests of members. **Recommendation for CoventryCares:** Coventry should document in the minutes the specific title/role of each member	Full	Addressed in the QMAC Charter. Demonstrated in the QMAC meeting minutes. The committee members include consumer advocates who represent the interests of members.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Responsibilities of the Committee shall include:	in attendance. For example, MCO member, community advocate with the organization represented/role of the attendee.		Coventry continues efforts to recruit MCO members for the committee.	
A. Providing review and comment on quality and access standards;	Minimal - Report #21, including QMAC meeting minutes demonstrated that primarily, the committee members are provided with information about Coventry and its various programs (Lock-In, HEDIS, PIPs). The QI Program Description, QI Work Plan and QI Evaluation were not presented to the committee for review and comment. In general, there were a few questions and comments from the committee members. **Recommendation for CoventryCares:** Coventry should ensure that the QMAC fulfills its purpose and feedback and input from the committee members is obtained. **MCO Response:** This has been added as a standing agenda item for 2015 and moving forward.	Minimal	Access topics were addressed at the Region 6 meeting only, quality was addressed at 3 of the meetings; however, no review or comments were solicited. **Recommendation for CoventryCares of Kentucky** Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination:** No change in review determination.	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC,

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Minimal - The QMAC meeting minutes do not provide evidence of review and comment on the Grievance and Appeals process or aggregated data on grievances and appeals in 2014. **Recommendation for CoventryCares:** Coventry should ensure that the QMAC fulfills its purpose and responsibilities as required by the contract. **DMS Response:** This element also scored Minimal in 2013 and DMS has concerns. **MCO Response:** This has been added as a standing agenda item for 2015 and moving forward.	Non-Compliance	Grievances and appeals were not addressed at any of the QMAC meetings. The QMAC meeting minutes do not provide evidence of review and comment on the Grievance and Appeals process or aggregated data on grievances and appeals in 2015. **Recommendation for CoventryCares of Kentucky** Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions.	**DMS Comment** This element scored minimal for three successive review years; therefore, the review determination is Non-Compliance. **MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Final Review Determination No change in review determination.	and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
C. Providing review and comment on	Non-Compliance - The QMAC meeting minutes do not provide	Non-Compliance	Member educational materials were	**MCO Response**

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Member Handbooks;	evidence of review of the Member Hand book. **MCO Response:** This has been added as a standing agenda item for 2015 and moving forward.		presented at the meeting for Regions 1 and 2 only. No input or comments from committee members were found. The Member Handbook was not addressed at any of the meetings. Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination** No change in review determination.	A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
D. Reviewing Member education materials prepared by the Contractor;	Non-Compliance - The QMAC meeting minutes do not provide evidence of review of Member education materials. **MCO Response:** This has been added as a standing agenda item for 2015 and moving forward.	Minimal	Member educational materials were presented at the Regions 1 and 2 meeting only. No input or comments from the committee members were found. **Recommendation for CoventryCares of Kentucky** Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination** No change in review determination	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
E. Recommending community outreach activities; and	Full - The QMAC meeting minutes include evidence of discussion of community outreach activities.	Non-Compliance	Discussion of community outreach was not found in any of the QMAC meeting minutes. **Recommendation for CoventryCares of Kentucky** Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination** No change in review determination.	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - The QMAC meeting minutes show that the committee reviewed policies that affect Members, such as co-pays, benefits, and enrollment.	Minimal	The following were presented at the various meetings: benefits for substance abuse, care management programs, recertification, and benefits and coverage. However, no comments from committee members were found. **Recommendation for CoventryCares of Kentucky**	**MCO Response** A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination** No change in review determination.	commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically.
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Substantial - The list of members is provided in Report #21. Based on the meeting minutes, there did not appear to be a	Substantial	Demonstrated in MCO Report #22, submitted quarterly. The report includes the committee activity and	**MCO Response** A clear and solid plan has been developed to address weaknesses that

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	standing committee membership, rather, varied members and advocates and community groups attended. **Recommendation for CoventryCares:** The QMAC should have a standing membership comprised of community advocates and members for consistency. Others can be invited to participate as guests. **MCO Response:** QMAC has been added as a regular committee in the 2015 QI Program Description, including the members, roles, responsibilities and meeting frequency. Documentation of member recruitment efforts will be maintained and discussed during the committee update at the QMOC meetings.		members/meeting attendees. Based on a review of the meeting minutes, there was not a consistent, standing committee membership. During the interview, Coventry indicated that the new format for QMAC meetings may facilitate member attendance and consistent member participants. **Recommendation for CoventryCares of Kentucky** Coventry should implement its plan for the new QMAC meeting format and ensure that the committee fulfills its required functions. **Final Review Determination** No change in review determination.	have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and other member materials. Four QMAC meetings per year will be

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				held across the Commonwealth. Regions will be paired geographically.
21.5 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - Coventry conducted CAHPS Surveys for the Adult, Child and CHIP populations in 2014. Report #22 indicates that he Provider Satisfaction Survey was completed in May 2014.The Survey was disseminated via Fax Blasts and in messages with provider remittance notices. There was an extremely low response rate; therefore, the MCO explored the use of an outside vendor to conduct the survey in Q3 2014. The MCO used a vendor to field a new Provider Satisfaction Survey in Q4 2014. The survey was fielded via telephone with 425 surveys completed. The results were to be presented to the QMOC in February 2015 and interventions will be developed to address the findings.	Full	Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys Coventry conducted the CAHPS surveys for Medicaid Adults, Medicaid Children, and CHIP. Evidenced in MCO Report #94 Member Surveys. Coventry conducted a Provider Satisfaction Survey via a vendor – The Meyers Group. Evidenced in MCO Report #95 Provider Surveys.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - The 2014 QI Work Plan indicates that the CAHPS report to the Department in August 2014. Report #22 and Report #94 for Q3 2014 document submission to DMS.	Full	Demonstrated in MCO Report #94 Member Surveys.	
Annually, the Contractor shall assess the need for conducting special surveys to	Full - The 2014 QI Work Plan indicates that surveys were conducted for member satisfaction with chronic case	Full	This requirement is evidenced in the 2014 Annual Evaluation.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	management (CCM) and disease management (DM) programs. Report #22 for Q1- Q4 2014 includes the monthly CCM survey results. Report #22 for Q2 2014 describes a Member Understanding Survey which is administered monthly to new enrollees to assess understanding of benefits and MCO processes. According to Report #22, the member satisfaction surveys for Disease Management (DM) and Neonatal Intensive Care Program and High Risk Obstetrics are conducted annually and were planned for Q4 2014. According to Report #22 for Q4 2014, the DM survey is fielded by the corporate branch and had not been sent as of 12/31/14.		Coventry reported results for the following member survey: New Member Survey – to assess member understanding of benefits and health plan materials. Coventry also conducted several surveys of providers to evaluate members' access: Provider Linguistic survey Telephone Appointment Availability survey After-hours Access survey	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full - The 2014 QI Work Plan and Report #22 indicate that the Provider Satisfaction Survey was completed in December 2014 and the report was to be presented to the QMOC in February 2015.	Full	Demonstrated in the 2015 QM Work Plan and MCO Report #95 Provider Surveys.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results.	Full - Coventry submitted Report #22 quarterly and Report #94 CAHPS to DMS as required.	Full	Coventry submitted MCO Report #95 Provider Surveys and MCO Report	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	The 2013 QI Evaluation contains the 2013 Provider Satisfaction Survey results. These report included methodology, response rates, and survey items.		#94 Member Surveys (CAHPS), including the methodology, response rates, survey items and results.	
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - Coventry submitted Report #22 quarterly and Report #94 CAHPS to DMS as required. The 2013 QI Evaluation contains the 2013 Provider Satisfaction Survey results. The report included the methodology, response rates, and survey item results.	Full	Coventry submitted MCO Report #95 Provider Surveys and MCO Report #94 Member Surveys (CAHPS).	
38.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full - Addressed in the 2014 QI Program Description, which states that the MCO will make available to state Medicaid agencies as contractually required and upon request all data, clinical and other records/reports for review of quality of care, access and utilization issues including, but not limited to, activities related to External Quality Review (EQR), HEDIS, encounter data validation, and other related activities. Evidenced in Coventry's submission of the 2014 QI Work Plan and quarterly updates, Report #17.	Full	Addressed in the 2015 QM Program Description and the 2015 QM Work Plan. Evidenced in Coventry's submission of MCO Report #84 2015 QM Program Description and 2015 QM Work Plan, MCO Report #85 Annual Evaluation, and quarterly work plan updates, MCO Report #17.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	85	5	6	3
Total Points	255	10	6	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.74**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

QI Program Description (MCO Report #84)
QI Work Plan (MCO Report #17)
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports (MCO Reports #19, 90 and 92)
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes

Reports

Annual QI Evaluation Report (MCO Report #85)
HEDIS Final Audit Report and IDSS rates (MCO Report #96)
Healthy Kentuckians Outcomes Measures Report
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of services
Evidence Based Guidelines for Practitioners (MCO Report #23)
MCO Committee Activity (MCO Report #21)

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
25.0 Member Grievances and Appeals				
25.1 General Requirements The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B. The Department, by or before January 1, 2016, shall provide a standardized form for all participating MCOs for a Member to begin the Contractor's grievance and appeal process.	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals, App-002 Appeals-Members, APP-003 Appeals – Grievances – Providers, App-004 Member Grievance, APP-005 Coordination with Subcontractors for Member G and A, APP-006 Transplant Appeal Process, APP-007 Critical Inquiries, APP-008 Spinal Surgery Appeals, App-009 State Fair Hearing.	
25.2 Member Grievance and Appeal Policies and Procedures				
The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in accordance with the notice, timeliness, rights and procedures in 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. These policies and procedures shall include, but not be limited to:	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals, App-002 Appeals-Members, APP-003 Appeals – Grievances – Providers, App-004 Member Grievance, APP-005 Coordination with Subcontractors for Member G and A, APP-006 Transplant Appeal Process, APP-007 Critical Inquiries, APP-008 Spinal Surgery Appeals, App-009 State Fair Hearing, the 2015 Member Handbook, section 10 Grievance and Appeals, the 2015 Provider Manual, section 10 A. Provider Complaint and Appeal Process and B. Member Grievance and Appeal Process, and in the appeal and grievance letter templates .	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
A. Provide the Member the opportunity to present evidence and allegations of fact or law, in person as well as in writing;	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals, App-002 Appeals-Members, the 2015 Member Handbook, section 10 Grievance and Appeals, and in the acknowledgement letter templates.	
B. Allow the Member or the Member's representative prior to and after the appeal to review the Member's case file;	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals, App-002 Appeals-Members, 2015 Member Handbook, section 10 Grievance and Appeals, and in the acknowledgement letter templates.	
C. Consider the Member, the Member's representative, or the legal representative of the Member's estate as parties to the appeal;	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals, App-002 Appeals-Members, 2015 Member Handbook, section 10 Grievance and Appeals, and in the acknowledgement letter templates.	
D. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Minimal - CoventryCares submits Report #29 Grievances and Appeals Narrative to DMS each quarter. The report describes the patterns in grievances and appeals for members and providers. For member and provider grievances, the report identifies categories of grievances which represent trends and opportunities for improvement. The report only presents the categories of grievances, e.g., access, claims	Full	Coventry prepares and submits MCO Report #27 Grievance Activity and #29 Grievances and Appeals Narrative. In response to prior compliance reviews recommendations, Coventry has reported more detailed analyses on grievances, identifying contributing factors and actions planned and taken. In addition, in response to desk audit recommendations, Coventry has reported follow-up on issues from one quarter to the next and reporting # received, #	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	payment, quality of care. The report does not contain data supporting the narrative (e.g., percentage of member grievances related to access versus other categories). The report does not identify the specific issue(s) that contribute to the trends/opportunities or specific actions. For example, percentage of complaints related to access to participating dental providers in a region, long appointment wait times in a region. For providers, claims processing issues related to use of a specific modifier. The report does not provide specific actions to be taken. For example, related to member access to care: the report indicates that CoventryCares continues to recruit providers, build relationships with the network and assist with provider education. More specific actions based on analyses such as those noted above would be expected. For provider claim issues, general and targeted educational efforts related to the specific claims issues for MCO staff or providers, as needed. Additionally, specific impact on policies, procedures, access and utilization are not provided. There is a		resolved, # pending for the quarter. Common categories included: Attitude and Service and Balance Billing by in-network providers. The MCO reported working with DMS Program Integrity to escalate issues related to balance billing.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	very general comment regarding CoventryCare's review of member/provider complaints/grievances to identify and address opportunities. **Recommendation for CoventryCares:** The MCO should perform and report more detailed analyses on grievances and appeals and identify the specific contributing factors as well as indicate the actions to be taken for the opportunities identified. **MCO Response:** CoventryCares of KY will include more specific data and information in future reporting.			
E. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	Substantial - As described in Aetna Medicaid Records Retention and Destruction Procedure, 4. Department-Specific Retention, Labeling and Storage, Record Series Code: INS 30-10-02, Record Series Subject: Complaints, Grievances and Appeals – Medicaid, Record Series Description: Records documenting complaints, grievances, and appeals from insured, members, providers or government agencies…including correspondence, supporting documents and resolution. Storage Medium and Location:	Substantial	A specific policy that addresses the requirement was not provided. During the interview, the MCO reported that all physical files are scanned and destroyed. Medical records are maintained in the IDX system and grievance and appeal documentation is maintained in Navigator. **Recommendation for Coventry** Coventry should include the specific language of this requirement in a policy and procedure.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Electronic Storage PHX Shared Drive; offsite. The wording of the policy appears to indicate that the grievances and all related documents are stored together. During the onsite review, CoventryCares provided screen prints of the appeals and grievances systems to show that documents cannot be accessed from the appeal/grievance screen but are uploaded/appended in a separate location. This appears to be the storage used for local plan purposes versus the long term storage referenced above. **Recommendation for CoventryCares:** The MCO should request that an appendix/exception be added to the Aetna Medicaid policy and procedure to address the Kentucky-specific requirements. **MCO Response:** CoventryCares of KY curr Appeals and Grievances in the database. **Final Review Determination:** No change in review determination. Coventry should ensure that the			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Kentucky Contract requirements are addressed in Aetna Policies and Procedures, whether through appending Kentucky-specific information (exceptions) or creating a Kentucky Medicaid specific Policy. Upon the next review, IPRO will evaluate the Policies and documentation to ensure same.			
F. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Member's health condition requires but not to exceed 30 days from its initiation;	Full-2014	Substantial	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results Addressed in policies and procedures for grievances and appeals, APP-001 through APP-009; the 2015 Member Handbook, section 10 Grievance and Appeals; the Provider Manual, section 10, B. Member Grievance and Appeals; and the G/A letter templates. <u>Member Grievance - Random File Review Results</u> 10 Random Member Grievance Files were reviewed. 8 of 10 were resolved timely, including 1 with a 14 day extension. <u>Member Grievance – Quality File Review Results</u> 10 Quality Member Grievances were	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			reviewed. 7 of 10 were resolved timely, including 3 with 14 day extensions. 3 of 10 were not applicable, as the members withdrew the grievances. Member Appeal File Review Results 10 Member Appeal Files were reviewed. 10 of 10 were resolved timely, including 2 expedited appeals. Member EPSDT Appeal File Review Results 5 EPSDT Member Appeals were reviewed. 5 of 5 were resolved timely, including 2 expedited appeals. **Recommendation for Coventry** Coventry should ensure that grievances and appeals are resolved timely, or if necessary, an extension is requested.	
G. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full-2014	Full	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results. Addressed in policies and procedures for grievances and appeals, APP-001 through APP-009; the 2015 Member Handbook, section 10 Grievance and Appeals; the Provider Manual, section 10, B. Member Grievance and Appeals; and the G/A letter templates.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Member Grievance - Random File Review Results 10 Random Member Grievance Files were reviewed. This was not applicable for 10 cases; there was no prior review necessary. Member Grievance – Quality File Review Results 10 Quality Member Grievances were reviewed. This was not applicable for 10 cases; there was no prior review necessary. Member Appeal File Review Results 10 Member Appeal Files were reviewed. 10 of 10 were fully compliant.	
H. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Full-2015	Full	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results. Addressed in policies and procedures for grievances and appeals, APP-001 through APP-009; the 2015 Member Handbook, section 10 Grievance and Appeals; the Provider Manual, section 10, B. Member Grievance and Appeals; and the G/A letter templates.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Member Grievance - Random File Review Results 10 Random Member Grievance Files were reviewed. This was not applicable for 10 cases, as the grievances were not related to clinical issues/medical necessity. Member Grievance – Quality File Review Results 10 Quality Member Grievances were reviewed. 3 of 3 cases related to clinical issues were fully compliant. Member Appeal File Review Results 10 Member Appeal Files were reviewed. 10 of 10 cases were fully compliant.	
I. Process for informing Members, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Full-2013	Full	Addressed in the Member Handbook. Addressed in policy and procedure APP-005 Coordination with Subcontractors for Member Grievances and Appeals. Addressed in subcontractor contracts, Appendix B-3.	
J. Provide assistance to Members in filing a grievance if	Full-2013	Full	Addressed in policy and procedure APP-	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
requested or needed;			004 Member Grievance. Addressed in the Member Handbook, Section 10, Grievance and Appeals (page 65). Addressed in the Provider Manual, Section 10, Complaint Process for Providers and Members, B. Member Grievance and Appeal Process. Demonstrated in the Member Grievance file review.	
K. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Non-Compliance - APP-002 Member Appeals, does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address lack of retaliation. APP-004 – Member Grievance, does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address lack of retaliation. The Member Handbook, Section 10, does not address that the MCO will not discriminate against a member based	Full	Addressed in policy and procedure APP-001 Expedited Appeals, App-002 Appeals-Members, APP-004 Grievance – Member, in the Member Handbook, Section 10 Grievance and Appeals and the Provider Handbook, Section 10 – Compliant Procedures for Providers and Members, B. Member Grievance and Appeal Process.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	solely on having filed a grievance or appeal. It does address lack of retaliation, that the MCO will not punish the member or provider for filing a grievance. APP-003 Appeals-Grievances-Providers does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address that the MCO will not retaliate against a provider based on filing or supporting an appeal, standard or expedited. Not discriminating against a member based solely on having filed a grievance or appeal was not found in the 2013-2014 or the 2015 Provider Manual, Section 10 Complaints Process Providers and Members. **MCO Response:** CoventryCares of KY will to the Provider Manual in the 2016 version stating no punitive action or retaliation will be taken against the member or member's representative for filing an Appeal or Grievance. **Final Review Determination:** No			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	change in review determination. Coventry should ensure that the statement "the MCO will NOT DISCRIMINATE" against a member/provider based on filing a grievance or appeal to the applicable Policies and Procedures, Member Handbook and Provider Manual. Upon the next review, IPRO will evaluate the Policies, Member Handbook, and Provider Manual to ensure same.			
L. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full-2013	Full	Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 67).	
M. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full-2014	Substantial	Includes Member Grievance Random and Member Grievance Quality file review results <u>Member Random Grievance File Review Results</u> 10 Random Member Grievance Files were reviewed. 6 of 10 were fully compliant. The remaining 4 had issues with incorrect wording making the notices not easily understood.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Member Quality Grievance File Review Results 10 Quality Member Grievance Files were reviewed. 7 of 7 files were fully compliant. The remaining 3 were not applicable as the members withdrew the grievances.	
N. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Substantial - Addressed in APP-004 Member Grievance and communicated to members in the Member Handbook. This requirement was not found in the Provider Manual, section 10 Complaint Process for Members and Providers, B. Member Grievance and Appeals Process. **Recommendation for CoventryCares:** The MCO should add the required language as it appears in the Member Handbook to the Provider Manual. **MCO Response:** Not sure what "required are looking for. **Final Review Determination:** No change in review determination.	Substantial	Addressed in policy and procedure APP-004 Grievance-Member. Addressed in the Member Handbook, Section 10 Grievance and Appeals. Not found in the Provider Manual as it relates to members. This is addressed for providers in Section 10, Complaint Process for Providers and Members, A. Provider Complaint and Appeal Process, but is not addressed in the B. Member Grievance and Appeal Process. **Recommendation for Coventry** Coventry should include language in the Provider Manual, Section 10, B Member Grievance and Appeal Process that addresses the member's right to appeal/grieve a grievance decision if the member is not satisfied with the decision.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Coventry should add the specific Contract language that appears in column 1, "J. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;" (Federal requirement 42 CFR 438.420) to the Provider Manual. Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.			
O. Provide for continuation of services, if appropriate, while the appeal is pending;	Substantial - Addressed in APP-002 and communicated to members in the Member Handbook on page 66. CoventryCares revised the Member Handbook to remove the requirement that the request for SFH must be filed within 10 days in order for services to continue. The contract wording regarding continuation of benefits pending appeal or State Fair Hearing has been included in the Member Handbook, page 66. Communicated to providers in the Provider Manual, page 108. The manual states that the member may request continuation of benefits during the appeal review or a State Fair Hearing; however, it does not provide	Full	Addressed in APP-001 Expedited Appeals (page 7) and APP-002 Appeals – Members (page 8). Addressed in the Member Handbook, Section 10 Grievance and Appeals on page 66. Addressed in the Provider Manual, page 110.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	the specific conditions noted in the contract. **Recommendation for CoventryCares:** The MCO should add the specific conditions in the contract to the Provider Manual statement regarding continuation of benefits pending appeal or State Fair Hearing. **MCO Response:** Not sure what "specific c the contract" they are asking for. **Final Review Determination:** No change in review determination. Coventry should add the specific conditions under which benefits will continue pending appeal as stated in column 1, K, 1-5 (Federal requirement 42 CFR 438.420). Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.			
P. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being;	Full-2014	Full	Addressed in policy and procedure APP-001 Expedited Appeals (page 2,3,4). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			64). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members, A. Provider Compliant and Appeal Process (page 108) and B. Member Grievance and Appeal Process (page 111).	
Q. Not require a Member or a Member's representative to follow an oral request for an expedited appeal with a written request;	New Requirement	Substantial	Addressed in policy and procedure APP-001 Expedited Appeals, (page 2 and 3-4). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 64). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members, A. Provider Complaint and Appeal Process (pages 8, 9) and B. Member Grievance and Appeal Process (page 110). **Recommendation for Coventry** Coventry should add a specific statement to the Member Handbook that "you do not need to file an expedited appeal in writing" and in the Provider Manual, "expedited appeals do not need to be filed in writing."	MCO did not provide a response.
R. Inform the Member of the limited time to present evidence and allegations of fact or law in the case of an	Full-2013	Full	Addressed in APP-001 Expedited Appeals (page 6).	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
expedited appeal;				
S. Provide written notice of the appeal decision;	Full-2014	Full	Addressed in APP-001 Expedited Appeals (page 6) and APP-002 Appeals – Members (page 7). Addressed in the Member Handbook, Section 10, Grievance and Appeals (page 63). Addressed in the Provider Manual, Section 10 Compliant Process for Providers and Members (pages 108, 109, 111).	
T. Provide for the right to request a hearing under KRS Chapter 13B;	Full-2014	Full	Addressed in policies and procedures APP-001 Expedited Appeal and APP-002 Appeals – Members. Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 66). Addressed in Appeal letter addendum.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
U. Provide for continuation of services, if appropriate, while the hearing is pending.	Substantial - Addressed in APP-002 and communicated to members in the Member Handbook on page 66. CoventryCares revised the Member Handbook to remove the requirement that the request for SFH must be filed within 10 days in order for services to continue. The contract wording regarding continuation of benefits pending appeal or State Fair Hearing has been included in the Member Handbook, page 66. Communicated to providers in the Provider Manual, page 108. The manual states that the member may request continuation of benefits during the appeal review or a State Fair Hearing; however, it does not provide the specific conditions noted in the contract. **Recommendation for CoventryCares:** The MCO should add the specific conditions in the contract to the Provider Manual statement regarding continuation of benefits pending appeal or State Fair Hearing. **MCO Response:** Not sure what "specific c the contract" they are asking for.	Substantial	Addressed in APP-001 Expedited Appeal (page 7-8) and APP-002 – Appeals – Members (page 8-9). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 66). Partially addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 110). The specific conditions for continuation of benefits are not stated as seen in the member handbook, page 66. **Recommendation for Coventry** Coventry should add the specific conditions for which the member's benefits may be continued to the information on appeals in the Provider Manual.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Coventry should add the specific conditions under which benefits will continue pending appeal as stated in column 1, O, 1-5 (Federal requirement 42 CFR 438.420). Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.			
V. Allows a Provider to file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010; and	Minimal - Addressed in APP-004 Member Grievance, page 3 and APP-003 Appeals and Grievances. Communicated to members in the Member Handbook on page 55 (version 1, 2014) and page 57 (version 2, 2014). Provider appeals and grievances are addressed in both the 2013-2014 and the 2015 Provider Manuals, Section 10. Communication to providers of the process for filing a grievance on behalf of a member was not addressed in either the 2013-2014 nor the 2015	Full	Addressed in APP-001 Expedited Appeal (page 2), APP-002 Appeals – Members (page 2), APP-004 Member Grievance (page 3, 4). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 61, 63-64). Addressed in the Provider Manual, Section 10 Compliant Process for Providers and Members (page 108, 110).	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Provider Manual, Section 10. Complaint Process for Providers and Members, B. Member Grievance and Appeals Process, The 2014 Provider Manual was not found in the documents submitted but was located on the MCO website. **Recommendation for CoventryCares:** CoventryCares should update the Provider Manual to include the process for a provider to file a grievance on behalf of a member. This element is scored Minimal because the MCO did not address the same recommendation for the prior two reviews. **MCO Response:** Will add statement to Provider Manual as found in the Member Handbook 2013-14 version "your provider can also file a grievance with your written permission." In the 2016 version.			
W. Notifies the Member that if a Service Authorization Request is denied and the Member proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Member may be liable for the cost.	New Requirement	Full	Addressed in policy and procedure APP-001 Expedited Appeal (page 8), APP-002 Appeals – Member (page 9). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			66). Addressed in the Provider Manual, Section Compliant Process for Providers and Members, B Member Grievance and Appeal Process (page 110). Addressed in the appeal letter addendum.	
If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: A. The Member withdraws the appeal, B. The Member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision, C. A State Fair Hearing decision adverse to the Member is made, or D. The service authorization expires or authorization limits are met.	Full-2014	Full	Addressed in policy and procedure APP-001 Expedited Appeal (page 7), APP-002 Appeals – Member (pages 8-9). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 66). Addressed in the Provider Manual, Section Compliant Process for Providers and Members, B Member Grievance and Appeal Process (page 110).	
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, an administrative hearing officer, judicial appeal, or closure of a file, whichever occurs later. The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or	Full-2013	Full	Addressed in policy and procedure APP-001 Expedited Appeal, APP-002 Appeals – Member, APP-003 Provider Appeals and Grievances, APP-004 Grievance – Member. Addressed in appeal and grievance letter addendum.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall b e made available to the Member, if requested.			Demonstrated by case files presented for review.	
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution. KAR S 17:010 Section 4 (2) (a)	Non-Compliance - Addressed in APP-004 Member Grievance. <u>Member Grievance File Review Results – Random</u> 8 of 11 files reviewed met requirements for acknowledgement. <u>Member Grievance File Review Results – Quality</u> 10 of 10 files reviewed met requirements for acknowledgement. This element is scored Non-Compliance because the MCO did not address the same recommendation for the prior two reviews. **MCO Response:** CoventryCares of KY has implanted an interdepartmental policy where all grievance resolution	Substantial	Includes Member Random and Member Quality Grievance file review results Addressed in policy and procedure APP-004 Grievance – Member (page 3, 4). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 62). <u>Member Random Grievance File Review Results</u> 10 Member Random Grievance Files were reviewed. 10 of 10 were fully compliant. <u>Member Quality Grievance File Review Results</u> 10 Member Quality Grievance Files were reviewed. 7 of 10 were fully compliant. 3 of 10 files did not contain	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	letters will be reviewed for proofing and member appropriate language prior to being finalized. Documentation and training of policies and procedures will be reviewed at each staff meeting. There will be a log kept of each training and staff members will have to sign off on the training. Currently have one staff member attending the Aetna Center for Writing Excellence and will have handouts and training in staff meetings for further education of staff members.		acknowledgment letters. These grievances were withdrawn after 5 days and should have been acknowledged. **Recommendation for Coventry** Coventry should assure that acknowledgement letters are sent timely.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Minimal – Member Grievance File Review Results – Random 9 of 11 files met the standard for timeliness. 7 of 11 files demonstrated a complete investigation. 6 of 11 resolution notices contained all information considered in the investigation. 6 of 11 files contained the findings and conclusions. 11 of 11 files contained the disposition of the grievance 6 of 11 resolution notices were written	Substantial	Includes Member Random and Member Quality Grievance file review results Addressed in policy and procedure APP-004 Grievance – Member (page 3, 5). Addressed in the Member Handbook, Section 10, Grievance and Appeals (page 62). Addressed in the Provider Manual, Section 10 B Member Grievance and Appeal (page 111). Member Random Grievance File Review	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	in a manner to ensure understanding. <u>Member Grievance File Review Results – Quality</u> 9 of 10 files met the standard for timeliness. 7 of 10 files demonstrated a complete investigation. 7 of 10 resolution notices contained all information considered in the investigation. 7 of 10 files contained the findings and conclusions. 10 of 10 files contained the disposition of the grievance 7 of 10 resolution notices were written in a manner to ensure understanding. Issues identified among the random and quality grievances, collectively, generally related to the thoroughness and documentation of the investigation, taking appropriate follow-up action and the clarity of the resolution notices. More specifically, there were: - 3 cases where the Grievance and Appeal (G/A) staff member accepted providers' verbal explanations without requesting/obtaining supporting		<u>Results</u> 10 Member Random Grievance Files were reviewed. 8 of 10 files met the standard for timeliness. 10 of 10 files demonstrated a complete investigation. 10 of 10 resolution notices contained all information considered in the investigation. 10 of 10 files contained the findings and conclusions. 10 of 10 files contained the disposition of the grievance 6 of 10 resolution notices were written in a manner to ensure understanding. <u>Member Quality Grievance File Review Results</u> 10 Member Quality Grievance Files were reviewed. 7 of 7 files met the standard for timeliness. The remaining grievances were withdrawn by the members. 10 of 10 files demonstrated a complete investigation. 7 of 7 resolution notices contained all information considered in the investigation. The remaining 3 grievances were withdrawn by the members. 7 of 7 files contained the findings and	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	documentation; - 1 case where the supporting documentation was not in the file; - 2 cases were misdirected internally, which caused delays; - 1 case was referred to the Provider Relations department and no action until almost 30 days later when the G/A dept followed up; - 3 cases where appropriate follow-up action was not taken; - 8 cases where the resolution notices were not written in a manner to ensure ease of understanding; and - 2 cases where a statement was made that the issue was not a CoventryCares error. **Recommendation for CoventryCares:** CoventryCares should implement an over-read procedure where letters written by Customer Service Representatives (CSRs) are proof-read for clarity, wording, grammar, spelling and typographical errors and appropriate wording for members prior to being sent.		conclusions. The remaining 3 grievances were withdrawn by the members. 7 of 10 files contained the disposition of the grievance. The remaining 3 grievances were withdrawn, but should have been closed with a resolution to the member. 7 of 7 resolution notices were written in a manner to ensure understanding. The remaining 3 grievances were withdrawn by the members. Coventry's grievance files are substantially improved from the prior review. Coventry implemented an over-read process and a case tracking log process. Investigation of the grievances was thorough and follow-up was evident. Some issues continue, including 2 (of 20) grievances that were not resolved timely; 4 (of 20) resolution letters with wording that was not clear; and 3 grievances that were withdrawn by the members and had no acknowledgement or resolution letter to the member. **Recommendation for Coventry** Coventry should continue the current over-read and quality check procedure to continue improvement in grievance processing.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	The MCO should share common issues at staff meetings to potentially prevent the same or similar errors occurring by multiple staff members. The MCO should discontinue the practice of copying and pasting internal notes into the resolution notices since the wording may not be appropriate may be awkward, out of context or may not be understood by members. For example, referring to the member in the third person, e.g., "the member reported..." and "the member may…" The MCO should avoid deferring fault by using statements such as "not a health plan error" since this could appear uncaring and offend the member. Better wording would just state the facts. The MCO should avoid the use of managed care "jargon" that members may not understand, e.g., "non-par provider" and "termed."			
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the	Full-2015	Full	Includes Member Random and Member Quality Grievance file review results Addressed in policy and procedure APP-004 Grievance – Member (page 3).	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe. 42 CFR 438.408 (c)			Addressed in the Member Handbook, Section 10, Grievance and Appeals (page 63). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 109, 111). <u>Member Random Grievance File Review Results</u> 10 Member Random Grievance Files were reviewed. 1 of 10 cases required an extension. The member did not request the extension. The member was notified in writing. The grievance was resolved within the 14 day extension. <u>Member Quality Grievance File Review Results</u> 10 Member Quality Grievance Files were reviewed. 3 of 10 cases required an extension. The member did not request these extensions. The member was notified in writing in all 3 cases. All 3 grievances were resolved within the 14 day extension.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)	Full-2014	Substantial	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeals – Member (pages 2-3). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 3). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 109). Addressed in the appeals letter addendum. <u>Member Adult Appeal File Review Results</u> 8 Member Adult Appeal files were reviewed. The remaining 2 were expedited appeals. 7 of 8 included timely acknowledgment letters. The remaining 2 were expedited appeals. <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. 2 were expedited appeals. 3 of 3 included timely acknowledgment letters. The remaining 2 were expedited appeals.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Coventry Coventry should assure that the acknowledgement letter is sent to the member in a timely manner.	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)	Full-2014	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeals - Member (pages 2, 6). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 62). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 111). Addressed in the appeals letter addendum. Member Adult Appeal File Review Results 8 Member Adult Appeal files were reviewed. The remaining 2 were expedited appeals. All files were resolved timely. Member EPSDT Appeal File Review Results 5/5 files were compliant. All were resolved timely.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Full-2013	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeals - Member (pages 2, 6). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 62). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 111). Addressed in the appeals letter addendum. <u>Member Adult Appeal File Review Results</u> 0 of 10 cases required an extenstion <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. The remaining 2 were expedited appeals. 0 of 5 cases required an extension.	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)	Full-2013	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeals - Member (pages 4, 5). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 63).	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 110). Addressed in the appeals letter addendum. <u>Member Adult Appeal File Review Results</u> 10 Member Adult Appeal files were reviewed. Two were expedited appeals. All files contained notification to the member/representative of the right to submit documentation. <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. 3/3 were compliant. Two were expedited appeals and decision was in favor of member and is NA. All files contained notification to the member/representative of the right to submit documentation.	
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall	Full-2013	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeals - Member (pages 1, 8). Addressed in the Member Handbook,	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)			Section 10 Grievance and Appeals (page 64, 65). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 110). Addressed in the appeals letter addendum. <u>Member Adult Appeal File Review Results</u> 10 Member Adult Appeal files were reviewed. All files were compliant. <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. 3/3 were compliant. 2 NA due to expedited appeals.	
For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information: 1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Full-2014	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-002 Appeal – Member (pages 7-8). Addressed in the Member Handbook, Section 10 Grievance and Appeals (page 63). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Members (page 111). Member Adult Appeal File Review Results 10 Member Adult Appeal files were reviewed. All files were resolved timely. All files contained the date and results. Member EPSDT Appeal File Review Results 5 Member EPSDT Appeal files were reviewed. All files were resolved timely. All files contained the date and results.	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)	Full-2014	Full	Includes Member Appeal file review results Addressed in policy and procedure APP-001 Expedited Appeals (page7) and APP-002 Appeal – Member (pages 7-9). Addressed in the Member Handbook, Section 10 Grievance and Appeal (pages 62-66). Addressed in the Provider Manual, Section 10 Compliant Process for Providers and Members (page110). Addressed in appeal letter addendum. Member Adult Appeal File Review Results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			10 Member Adult Appeal files were reviewed. 6/6 were compliant for all areas. 4 NA <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. 3/3 were compliant for state fair hearing 3/3 were compliant for the right to request receipt of benefits 3/3 were compliant for member may be liable for cost	
Expedited Appeals File Review				
The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)	Full-2013	Substantial	Includes review results for Member Appeals if expedited Addressed in policy and procedure APP-001 Expedited Appeals (pages 2, 6). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 64). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 108, 110). <u>Member Adult Appeal File Review Results</u> 10 Member Adult Appeal files were reviewed. Two were expedited appeals.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			2 of 2 were resolved timely. 0 of 2 had documentation of attempt to provide oral notice. 2 of 2 contained written notice. Member EPSDT Appeal File Review Results 5 Member EPSDT Appeal files were reviewed. Two were expedited appeals. 2 of 2 were resolved timely. 0 of 2 had documentation of attempt to provide oral notice. 2 of 2 contained written notice. **Recommendation for Coventry** Coventry should make an attempt to notify the member orally for expedited appeals.	
The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay. KAR 17:010 Section 4 (14) (d) and (15)	Full-2013	Full	Includes review results for Member Appeals if expedited Addressed in policy and procedure APP-001 Expedited Appeals (pages 2, 6). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 64). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 108, 110). Member Adult Appeal File Review Results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			10 Member Adult Appeal files were reviewed. Two were expedited appeals. Extensions were not required for either case. <u>Member EPSDT Appeal File Review Results</u> 5 Member EPSDT Appeal files were reviewed. Two were expedited appeals. Extensions were not required for either case.	
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Full-2013	Substantial	Includes review results for Member Appeals if expedited Addressed in policy and procedure APP-001 Expedited Appeals (pages 2, 6). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 64). Addressed in the Provider Manual, Section 10 Complaint Process for Providers and Members (page 108, 110). <u>Member Adult Appeal File Review Results</u> 10 Member Adult Appeal files were reviewed. Two were expedited appeals. 2/2 NA as the approval was within 1 day and additional evidence not required.	MCO did not provide a response.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Member EPSDT Appeal File Review Results 5 Member EPSDT Appeal files were reviewed. Two were expedited appeals. 2/2 did not show that the member was told of a limited time to present evidence. **Recommendation for Coventry** Coventry should notify the member of the limited time to provide evidence for expedited appeals.	
25.3 State Hearings for Members				
A Member may not file a grievance with the state. A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor within forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an Action taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B.	Full-2013	Full	Addressed in policies and procedures APP-001 Expedited Appeals (pages 2, 8-9) and APP-002 Appeal – Member (page 2, 9-10). Addressed in the Member Handbook, Section 10 Grievance and Appeal (page 66). Addressed in the Provider Manual, Section 10 Compliant Process for Providers and Members (page 110). Addressed in appeal letter addendum.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member. The contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services. The Department shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.				
28.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that a Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. The Department on or by January 1, 2016, shall approve a standard Provider Grievance Form to be used by the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the	Full-2014		Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the Appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or Appeals shall be resolved and the Provider shall receive the resolution within thirty (30) calendar days. If the grievance or Appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals. A Provider does not have standing to request a State Fair Hearing.				
28.11 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Full-2013	Full	Addressed in provider and vendor contracts. Addressed in Provider Manual, Section 10 Compliant Process for Providers and Members.	
38.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances	Substantial - Reports #27, #28 and #29 are reviewed with quarterly desk	Full	Includes review of MCO Reports: #27 Grievance Activity	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	audits conducted by IPRO. Recommendations based on the review are below. **Recommendation for CoventryCares:** Actions taken by the MCO in response to analysis of grievances should be more specific. Issues identified in one quarter should be updated in subsequent quarters until resolved. The narrative report should include total # of grievances received, total # resolved and number/percent of grievances resolved within 30 days. The same issues and actions were reported each quarter. CCKY should assess the effectiveness of its actions and implement revised or new actions. **MCO Response:** More specific details will in future reporting.		#28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) Reports #27, #28 and #29 are reviewed with quarterly desk audits conducted by IPRO. Coventry has addressed the recommendations from the desk audits in subsequent reports.	
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	Non-Compliance - No documentation related to this requirement was located.	Non-Compliance	No documentation provided in the pre-onsite documents. Discussed onsite and requested documentation. Not found in onsite documentation submission.	MCO did not provide a response.

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings
Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	32	11		1
Total Points	96	22		0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.68**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings
- Maintenance of grievance records

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data
Process for evaluating patterns of grievances
Sample letters for notice of action, grievance resolution and appeal resolution

Reports

Quarterly reports of grievances and appeals (MCO Reports #27, 28 and 29)

File Review

Member and Provider grievance files for a sample of files selected by EQRO
Member and Provider appeal files for a sample of files selected by EQRO
QI Committee minutes or other documentation demonstrating investigation and any action taken for individual grievance and appeal files selected for review by the EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
35.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Full-2013	Full	This requirement is addressed in Policy CM-022: "The process is intended to assess, monitor, evaluate and identify chronic disease, injury risks, modifiable risk factors and urgent health needs of an individual. Additionally, each member will be encouraged to develop a personal health plan that promotes wellness and a healthy lifestyle." The process for HRA is described further in Policy CM-021.Case and disease management addressed in Member Handbook.	
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Minimal - **HRA File Review Results:** A total of 25 files were reviewed. 12/25 files included evidence of a timely initial outreach attempt. No evidence of outreach was found for the remaining 13 files. 10/12 files receiving initial outreach included timely follow-up attempts when the initial attempt was unsuccessful. Follow-up in 2 files was not applicable (member completed HRA at first attempt). **Recommendation for CoventryCares:** All new members should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.	Full	Includes HRA file review results This requirement is addressed in Policy CM-022. <u>HRA File Review Results</u> A total of 19 files were reviewed. 5/19 files had a completed HRA, and all included evidence of a timely outreach attempt. If the first attempt was unsuccessful, additional phone calls/mailing attempts were made in a timely manner.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	DMS Response: This is the third year in a row that the MCO has received a Minimal in this element. A CAP was issued for this element the past three years with minimal success. DMS has concerns. **MCO Response:** Members previously enrolled with another health plan were not excluded from the universe. The health plan will exclude members not eligible for audit in the future. **Final Review Determination:** No change in review determination. This was discussed with DMS. Coventry's interpretation of the requirement is incorrect. The requirement is that the MCO is required to conduct/attempt an HRA for ALL members who are newly enrolled in the MCO, and who have not been enrolled in that MCO in the past 12 months, regardless if the member was enrolled in another MCO previously. The intent of the HRA is that the current MCO obtain information on risk factors for the members that are new to that MCO who have not been enrolled in the MCO in the prior 12 months. Each MCO's file review sample is drawn from all members newly enrolled in the MCO. Members who were previously enrolled in another MCO are NOT valid exclusions.			

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	It is expected that the MCO provide a full list of new enrollees during the required timeframe as requested. IPRO will remove members who meet exclusion criteria (e.g., enrolled in that MCO in the prior 12 months).			
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire which includes the survey instrument for both substance use and mental health disorders.	Substantial - 2014 **HRA File Review Results:** 3/25 members contacted completed an HRA. All 3 HRAs were provided for review. Required components were addressed in 2 files. Current behavioral health status including screening for substance use and mental health disorders was lacking in one file. **Recommendation for CoventryCares:** The MCO should ensure that all required screening is completed. **Recommendation for DMS:** DMS may want to consider developing, in consultation with the MCOs, either: a standardized HRA tool for use across MCOs, or a list of minimally required contents for MCO-specific HRA tools. DMS may also consider specifying in the MCO contract, the minimum number of outreach attempts and the types of methods to be used, such as at least 3 outreach attempts using at least 2 different methods. **MCO Response:** Members may intentionally choose not to answer all questions in the survey.	Full	Includes HRA file review results This requirement is addressed in Policy CM-021. <u>HRA File Review Results</u> 19/19 were compliant for multiple attempts to contact 5 of the 19 CoventryCares members that were contacted completed an HRA.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Vendor does not document why a question was not answered, but this will be part of the process upon migration to Aetna. MCO cannot force member to answer all questions. Future Aetna process will include reasons documented for incomplete assessment. **Final Review Determination:** No change in review determination. It is understood that no items in the HRA are mandatory for the member's response. The MCO's HRA should have a method to indicate that a member refused to answer any item and/or if an item is not applicable, whether via written response, phone interview, or other. Without this, it is not clear if the item(s) were skipped or missed inadvertently.			
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.	Minimal - 2014 **HRA File Review Results:** Incomplete demographic information was evident in all 3 files that included a completed HRA. Current behavioral health status including screening for substance use and mental health disorders was lacking in one file. **Recommendation for CoventryCares:** The MCO should ensure that all required screening is completed and that the HRA includes complete demographic information. **MCO Response:** The vendor is able to submit	Minimal	Includes HRA file review results. This requirement is addressed in Policy CM-022. <u>HRA File Review Results</u> 19/25 files reviewed. 5 files had HRA completed. 1 (child) had demographic info, 4 (adults) did not; this question will be included this year into adult records, as per CoventryCares. 4/5 records had behavioral health status assessed, and need for care management was dependent upon risk score.	Demographic information is available on the HRQ in Dynamo. There is also a cover letter that will accompany all mailed HRQ's for those members that we are unable to reach.

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	"Good Health Profiles" at next audit. **Final Review Determination:** No change in review determination. Coventry needs to clarify the response.		**Recommendation for CoventryCares of Kentucky** Coventry should ensure all required screening is completed and that adult HRA includes complete demographic info. **Final Review Determination** No change in review determination.	
The Contractor shall use appropriate healthcare professionals in the assessment process.	Full-2013	Full	This requirement is addressed on page 2 of CoventryCares' Policy CM-022: "Appropriate healthcare professionals will be utilized to facilitate the completion of the HRA."	
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders.	Full-2014	Full	This requirement is addressed in Policy CM-022.	
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.	Full-2013	Full	Includes review of MCO Report #79 Health Risk Assessments The Plan provided 5 quarterly reports in Excel format which included the information required by state contract requirements.	

Final Findings
Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	6	0	1	0
Total Points	18	0	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.71**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Health Risk Assessment
Suggested Evidence

Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

File Review

File review of a sample of cases selected by the EQRO

Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals (MCO Report # 79)

Evidence of monitoring of health screening assessment completion rates, and follow-up actions to increase completion rates

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Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.2 Provider Credentialing and Recredentialing				
The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), 907 KAR 1:672 and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Members. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."** The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**" Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Members before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. A	Full-2013	Full	The requirement that the MCO conduct credentialing and recredentialing in compliance with NCQA standards is addressed on page 6 of the Practitioner Credentialing, Recredentialing Policy and KY Amendment. The requirement that the MCO complete the credentialing or recredentialing of a provider within 90 days is addressed on page 33 of the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This requirement as it pertains to the ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles is addressed on page 2 of the Practitioner Credentialing, Recredentialing Policy and KY Amendment and also in the Reporting Sanctions Policy.	

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Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
Appendix J				
This documentation shall include, but not be limited to:				
defining the scope of providers covered,	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy.	
the criteria and the primary source verification of information used to meet the criteria,	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy.	
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment on page 11.	
Those providers accountable to a formal governing body for review of credentials shall include physicians,	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.			Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.	Full-2013	Full	This requirement is addressed in Coventry's geo access reports and data.	
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment on page 11.	
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner	

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additional information as may be specified by the Department.			Credentialing, Recredentialing Policy and KY Amendment.	
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment on page 9.	
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment on page 10.	
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment on page 11. The Delegated Credentialing	
C. A review of the credentialing policies and procedures by the formal body;	Full-2013	Full	This requirement is addressed in the Assessment Credentialing of Organizational Providers Policy and in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	

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D. A credentialing committee which makes recommendations regarding credentialing;	Full-2013	Full	This requirement is addressed in the Committee Minutes Policy and Procedure and in the Credentialing Allied Health Practitioners Policy on page 5. The MCO refers to this committee as the Credentialing and Performance Committee (CPC). The MCO supplied meeting minutes from the CPC to show evidence of the Committee making recommendations regarding credentialing processes.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2013	Full	This requirement is addressed in the Assessment, Credentialing of Organizational Providers Policy. This document contains provisions that should the function of credentialing be delegated, the effectiveness of such delegation would be monitored.	
F. Written procedures for the termination or suspension of Providers; and	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy.	
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Full-2015	Substantial	Includes Credentialing file review summary results This requirement is addressed on page 3 of the Practitioner Application Policy.	MCO did not provide a response.

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			Credentialing File Review Results Ten (10) initial credentialing files were reviewed. 10/10 files were timely and contained all requirements with the exception of 3 files that were missing the SAM exclusion checks. Ten (10) recredentialing files were reviewed. 10/10 files recredentialing files contained all requirements. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry add the SAM exclusion checks into all credentialing files.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. Coventry's credentialing files verify this information.	

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D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. Board certification is verified in each credentialing file.	
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
F. Previous five (5) years work history;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
G. Professional liability claims history;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
I. Current, adequate malpractice insurance, as verified through attestation;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This	

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			information is verified in Coventry's credentialing files.	
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
M. Documentation of censure by the State or County professional association;	Full-2013	Full	This requirement is addressed on page 3 of the Practitioner Application Policy. This information is verified in Coventry's credentialing files.	
N. Most recent information available from the National Practitioner Data Bank;	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, and State Licensing Authorities Policy. This information is verified in Coventry's credentialing files.	
O. Health and Human Services Office of Inspector General (HHS OIG); and	New Requirement	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy. This information is verified in Coventry's credentialing files.	
P. System for Award Management (SAM).	New Requirement	Non-Compliance	Missing from the documentation is language in a policy or procedure that pertains to the MCO verifying SAM when credentialing or recredentialing providers.	MCO did not provide a response.
The provider shall complete a credentialing application				

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that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
B. Lack of present illegal drug use;	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
C. History of loss of license and felony convictions;	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
D. History of loss or limitation of privileges or disciplinary activity;	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
F. Applicant attests to correctness and completeness of the application	Full-2013	Full	This requirement is addressed in the Practitioner Application Policy on page 3. The credentialing application includes this information.	
Before a practitioner is credentialed, the Contractor shall verify information from the following				

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organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy. This information is included in Coventry's credentialing files.	
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy. This information is included in Coventry's credentialing files.	
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2013	Full	This requirement is addressed in the Reporting Sanctions NPDB, HIPDB, State Licensing Authorities Policy. This information is included in Coventry's credentialing files.	
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Full-2013	Full	This requirement is addressed on page 5 of the Assessment, Credentialing of Organizational Provider Policy. This information is included in Coventry's credentialing files.	
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Full-2013	Full	This requirement is addressed on page 7 of the Assessment, Credentialing of Organizational Provider Policy. The MCO uses an on-site assessment form (Attachment B-I) to evaluate the site. This information is included in Coventry's credentialing files.	
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors	Full-2013	Full	This requirement is addressed on page 7 of the Assessment, Credentialing of Organizational Provider Policy. The MCO	

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organizational standards and this contract.			documents their evaluation of each site's record keeping practices via the Organization Further Investigation Roster. This information is included in Coventry's credentialing files.	
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Full-2013	Full	Includes Recredentialing file review summary results This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. <u>Recredentialing File Review Results</u> 10/10 recredentialing files contained all required elements. 10/10 recredentialing files reviewed were timely. In all files, the providers were recredentialing well before the 3 year time period. All files contained evidence that Coventry verified each provider for sanctions and limitations on service.	
A. A current license to practice;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is included in Coventry's credentialing files.	
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is included in Coventry's credentialing files.	
C. A valid DEA number, if applicable;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing	

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			Policy and KY Amendment. This information is included in Coventry's credentialing files.	
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is included in Coventry's credentialing files.	
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is included in Coventry's credentialing files.	
F. A current signed attestation statement by the applicant regarding:	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is included in Coventry's credentialing files.	
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. The signed attestation by the applicant includes this information and is included in Coventry's credentialing files.	
2. The lack of current illegal drug use;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. The signed attestation by the applicant includes this information and is included in Coventry's credentialing files.	
3. A history of loss, limitation of privileges or any disciplinary action;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing	

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			Policy and KY Amendment. The signed attestation by the applicant includes this information and is included in Coventry's credentialing files.	
4. Current malpractice insurance;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. The signed attestation by the applicant includes this information and is included in Coventry's credentialing files.	
5. Health and Human Services Office of Inspector General (HHS OIG);	New Requirement	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. The signed attestation by the applicant includes this information and is included in Coventry's credentialing files.	
6. System for Award Management (SAM).	New Requirement	Non-Compliance	Missing from the documentation is language in a policy or procedure that pertains to the MCO verifying SAM when credentialing or recredentialing providers.	MCO did not provide a response.
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
A. The national practitioner data bank;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is verified in Coventry's recredentialing files.	

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B. Medicare and Medicaid;	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is verified in Coventry's recredentialing files.	
C. State boards of practice, as applicable; and	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is verified in Coventry's recredentialing files.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This information is verified in Coventry's recredentialing files.	
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	

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and services.				
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment.	
29.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network and at least one teaching hospital.	Full-2013	Full	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy and KY Amendment. This requirement is also addressed in the Provider Recruitment, Network Shortage Policy.	

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In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech therapists, physical therapists, occupational therapists, private duty nursing agencies, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavioral Health Services Organizations, Certified Family, Youth and Peer Support Providers, Licensed Clinical Social Workers, Targeted Case				

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Managers, and other independently licensed behavioral health professionals. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file formally known as OSCAR provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.	Full-2013	Full	This requirement is addressed in the CVC Policy and Procedure.	
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not	Full-2013	Full	This requirement is addressed in the Section and Retention of Network Policy on page 1.	

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discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.				
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.	Full-2013	Full	This requirement is addressed in the Section and Retention of Network Policy on page 3.	
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Full-2013	Full	This requirement is addressed in the Section and Retention of Network Policy on page 2.	
29.2 Out-of-Network Providers				
The Department will provide the Contractor with an expected enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.	Full-2013	Full	This requirement is addressed in the Provider Recruitment, Network Shortage Policy.	
29.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-	Full-2013	Full	This requirement is addressed in the Section and Retention of Network Policy.	

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service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
29.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating	Full-2013	Full	This requirement is addressed in the CVC Policy. Coventry uses the Medicaid Provider number as the provider identifier when transmitting information or communicating about a provider to the Department.	

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about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.				
29.5 Enrolling New Providers and Providers not Participating in Medicaid				
A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied. All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.	Full-2013	Full	This requirement is addressed on page 1 of the Provider Recruitment, Network Shortage Policy.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
29.6 Termination of Network Providers or Subcontractors				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.	Full-2013	Full	This requirement is addressed in the Reporting Sanctions, State Licensing Policy and is communicated to the providers in the Provider Agreement.	
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Full - 2015	Full	This requirement is addressed in the Reporting Sanctions, State Licensing Authorities Policy. Credentialing Allied Health Practitioners Policy also addresses this requirement.	
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider within three business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2013	Full	This requirement is addressed in the Reporting Sanctions, State Licensing Authorities Policy.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and within 30 days for any other Provider.	Full-2015	Full	This requirement is addressed in the Member Handbook on pages 7 through 9. This requirement is also addressed in the Member Rights and Responsibilities Policy.	
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly, via the Provider Termination Report. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2013	Full	This requirement is addressed in the CVC Policy and in the Practitioner Participation and Peer Review CCKY Plan Amendment.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) 30 days prior to the effective date of the termination or (ii) within 15 days of receiving notice.	Full-2015	Full	This requirement is addressed in the Member Handbook on pages 7 through 9.	
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Full-2015	Full	This requirement is addressed in the Provider Manual and the Provider Agreement.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider	Full-2015	Full	This requirement is addressed in the Member Handbook on pages 7 through 9.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
within the previous six months. Such notice shall be mailed the later of the following: (i) within 15 days of providing notice or (ii) 30 days prior to the effective date of the termination.				

IPRO
Improving Healthcare for the Common Good

Final Findings

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	85	1	0	2
Total Points	255	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.92**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings
Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
Suggested Evidence

Documents

Policies and Procedures for:

- Enrollment of network providers
- Enrollment of out-of-network providers
- Provider Credentialing and Recredentialing including delegated credentialing
- Monitoring of provider sanctions, complaints and quality issues between recredentialing cycles
- Altering conditions of participation
- Termination/Suspension of providers
- Initial and ongoing assessment of organizational providers

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing
Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination
Sample provider file report of provider credentialing for DMS Fiscal Agent
Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

Sample of Credentialing and Recredentialing files for varied provider types selected by the EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.	Full-2013	Full	This requirement is addressed in the Provider Manual under the Primary Care Provider Responsibilities Section. Coventry performs annual access and availability surveys of PCPs and Specialists. The final reports are sent to the Department.	
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Full-2013	Full	This requirement is addressed in the Appeals Members Policy. This requirement is communicated to the members in the Member Handbook and to the providers in the Provider Manual.	
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full-2013	Full	This requirement is addressed in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Manual.	
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full-2013	Full	Referrals for specialty care providers both in and out of network is addressed in the Provider Manual.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2013	Full	This requirement is addressed in the Provider Manual.	
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2013	Full	This requirement is addressed in the Advanced Directives Policy. This requirement is communicated to the providers in the Provider Manual and to the members in the Member Handbook.	
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;	Full-2013	Full	This requirement is addressed in the EPSDT Program and is communicated to the providers in the Provider Manual.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2013	Full	Complete and accurate medical record documentation is addressed in the Provider Manual.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2013	Full	Referrals to behavioral health providers are addressed in the Provider Manual.	
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy and is communicated to the providers in the Provider Manual.	
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 contains data pertaining to after-hours accessibility. There were 204 total after-hours calls during the review period. The PATS data shows evidence that 87.25% of after-hours calls (178 calls) were answered by Coventry's service. The service transferred calls to the provider in 13 of the 178 calls, the service indicated that the provider would return the call within 30 minutes in 134 of 178 calls, or the call was answered directly by a provider on call in 31 of 178 calls.	
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 contains data pertaining to after-hours accessibility. There were 204 total after-hours calls during the review period. The PATS data shows evidence that 12.75% of after-hours calls (26 calls) were answered by a recording directing the member to call a medical practitioner that is designated to return the call within a maximum of 30 minutes.	
(3) Office phone is transferred after office hours to another location where someone will answer the phone	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.			The PATS Call Data 2015 indicates that the after-hours office phone is not transferred to another location.	
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 provides evidence that the office phones are answered after-hours.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 provides evidence that the office phones are answered after-hours and that members are not prompted to leave a message or go to the emergency room for any needed services.	
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 provides evidence that the office phones are answered after-hours and that members are not prompted to leave a message or go to the emergency room for any needed services.	
(4) Returning after-hours calls outside of thirty (30) minutes.	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy. The PATS Call Data 2015 provides evidence that the office phones are answered after-hours	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			and that members have their calls returned within 30 minutes as required.	
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 as 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.	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	
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.	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy.	
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:	Full-2013	Full	This requirement is addressed in the Emergency and Post Stabilization Services Policy.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Member residence in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Full-2013	Full	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy. PATS Call Data 2015 indicates full compliance with appointment and waiting times; routine and preventive service appointments were 30	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			days or less and urgent care was provided within 48 hours. Report 12A All 8 regions, including the urban and rural areas (where applicable) and all counties within each region, showed access to PCPs at 100% for compliance with both the mileage and minutes requirements.	
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.	Full-2014	Full	This requirement is addressed in the Accessing Appointment Availability Policy and in the Provider Accessibility and Availability Policy.	
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than 25% 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 21 years of age. Access to Specialists shall not exceed 60 miles or 60 minutes. In the event there are less than 5 qualified Specialists in a particular Medicaid region, the 25% shall not apply to that Medicaid region.	Full-2014	Full	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy. Report 12A All urban and rural regions and their respective counties showed 100% access. Coventry reported the specialist type in the provider listing but does not report access for specific Specialist types. It is recommended that Coventry report access findings for specialists by their specialty and that specialists no longer be reported in the aggregate.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Immediate treatment for any Emergency Medical Services or Emergency Mental Health Disorder or Substance Abuse Disorder Services by a health provider that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Full-2013	Full	This requirement is addressed in the Emergency and Post stabilization services Policy.	
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.	Full-2013	~~Substantial~~ Full	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy. Report 12A All regions reported 100% for hospitals with regards to the mileage requirement. For urban areas, gaps for access in minutes were seen in Region 2, McLean (89.1%) and overall access of 99.7%; Region 3, LaRue (90%), Meade (78.4%), and Nelson (99.7%) and an overall access of 99.3%. For rural regions, gaps for access in minutes were seen in Region 8, Harlan (81.3%) and Letcher (99.3%) and overall access of 99.8%. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry continue to examine gaps in access as they pertain to the minutes travelled for hospital access.	**MCO Response** As described in the findings, Coventry is meeting overall access above 99%. Coventry is not able to identify hospitals that reside in the counties listed with the exception of Harlan. We are in conversations with ARH to possibly bring this system into our Network. Coventry continues to monitor access and if a member needs services, we will authorize that service even to a non-par if needed.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Final Review Determination The MCO met the requirement in mileage at 100%.	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 3 weeks for regular appointments and 48 hours for urgent care.	Full-2013	Full	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy. The PATS Call Data 2015 indicates full compliance with regular appointment times and urgent care appointment times; that waiting times not exceed 3 weeks for a regular appointment or 48 hours for urgent care. Report 12A All 8 regions, including the urban and rural areas (where applicable) and all counties within each region, showed access to dental providers at 100% for compliance with the mileage and minutes requirements.	
G. Access for general vision, laboratory and radiology services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 30 days for regular appointments and 48 hours for Urgent Care.	Full-2013	Minimal	Includes review of MCO Report #12A Geo Access Network Reports & Maps(see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy.	**MCO Response** Coventry's Other Specialty report does include Radiology in the provider pool. Separate reports are provided for Vision by our vendor Avesis. The Report is produced based on the specifications outlined in the contract with the State as it does not request the specialties to be run by each individual provider type.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Report 12A Reports for access to vision, lab or radiology providers were not provided. Coventry does not break out specialists by specific provider types. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its access to vision providers and break out its reporting of specialists by specific provider types, including but not limited to, laboratory and radiology services. **Final Review Determination** No change in review determination. Regarding the MCO's response: - Specialists - agreed that the report follows state specifications and specific provider types are not required. This recommendation has been made to DMS as an improvement to the GeoAccess reports. - Radiology – per the contract requirement, access to radiology providers should be specifically demonstrated. - Laboratory - per the contract requirement, access to laboratory providers should be specifically demonstrated. - Vision – the MCO did not provide the vendor reports for review, therefore, is not compliant with the requirement to	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			demonstrate required access to vision providers. The MCO should ensure that in the future, access per contract requirements, is reported for each of the following: vision, radiology, and laboratory providers.	
H. Access for Pharmacy services shall not exceed 60 miles or 60 minutes or the delivery site shall not be further than 50 miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.	Full-2013	Substantial	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Accessibility and Availability Policy and in the Availability of Practitioners Policy. Report 12A 6 urban regions had gaps in access by miles – Regions 2, 3, 4, 5, 6 and 7 with no rates less than 90%. 3 urban regions had rates of less than 90% for access by minutes – Region 3 (84.9%), Region 6 (88.6%), and Region 7 (50.2%). **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry continue to examine gaps in access to pharmacies with regards to both the mileage and minutes requirements. **Final Review Determination**	**MCO Response** In reviewing the most recent report, Region 3 is the only area that is below 95% as it as 92.7%. Coventry has an agreement with CVS so we expect the percentage for Region 3 will increase.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			No change in review determination. The review findings are based on the documentation provided for the January onsite review.	
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program by Medicaid Region to provide out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services. In the event there are less than five (5) qualified Mental Health and Substance Abuse providers for both adults and children in a particular Medicaid Region, the fifty (50%) percent shall not apply to that Medicaid Region.	New Requirement	Non-Compliance	This requirement is missing from the submitted documentation. This language is not contained in a policy or procedure. **Final Review Determination** No change in review determination.	This requirement is part of the new agreement with the State that was effective 7/1/2015. Coventry's updated policy will include this language in the updated policies.
J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective	New Requirement	Non-Compliance	This requirement is missing from the submitted documentation. This language is not contained in a policy or procedure. **Final Review Determination** No change in review determination.	This requirement is part of the new agreement with the State that was effective 7/1/2015. Coventry's updated policy will include this language in the updated policies.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
members in the Medicaid Region.				
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following Providers in its network as follows:				
1. Teaching hospitals;	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	
2. FQHCs and rural health clinics;	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	
3. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	
4. Community Mental Health Centers	Full-2013	Full	This requirement is addressed in the Provider Accessibility and Availability Policy.	
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	Full-2014	Full	This requirement is addressed in the Provider Recruitment, Network Shortage Policy and in the Availability of Providers Policy.	
B. In consideration of the role that Department for Public Health, which contracts with the local health departments plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
1. Coverage of the Preventive Health Package pursuant to	Full-2013	Full	This requirement is addressed in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
907 KAR 1:360.			Recruitment Policy and in the Provider Agreement.	
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2013	Full	This requirement is addressed in the Selection and Retention of Network Policy.	
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Full-2014	Full	This requirement is addressed in the Provider Recruitment Policy and in the Selection and Retention of Network Policy.	
C. The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.	Full-2014	Full	This requirement is addressed in the Provider Recruitment Policy and in the Selection and Retention of Network Policy.	
29.9 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix L that demonstrates that the Contractor has an adequate network that meets the Department's standards in Section 29.7. The Contractor shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.	Full-2013	Substantial	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the Provider Recruitment Policy and in the Selection and Retention of Network Policy. Report 12A for Quarter 3 identified gaps in coverage in the following areas:	The overall access for hospitals is meeting the required access standard set in the contract with the State. We agree with findings on Urgent Care Centers and currently working on data in system to adequately identify and report these providers. Coventry has contracted with all available FQHCs in the marketplace. Disagree with Pharmacy as outlined in earlier explanation. Agree with Family Planning and continue to review options. Vision and Radiology were addressed in earlier

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Hospital access was 100% for mileage in all counties. Hospital access in minutes had gaps in Regions 2, 3 and 8. Urgent Care Centers had gaps in access by miles for Regions 1, 2, 3, 4, 6, and 7. (Note, there was an improvement in this area from 2014). Rates of access by minutes had gaps in access in Regions 1, 2, and 7. FQHCs had gaps in access by miles for Regions 1, 2, and 3. Gaps in access by minutes were found in Regions 1, 2, and 7. Pharmacies had gaps in access by miles in Regions 2, 3, 4, 5, 6 and 7. Gaps in access by minutes were found in Regions 3, 6, and 7. Family Planning Clinics had gaps in access by miles for Regions 2, 4, 5, and 7. Gaps in access by minutes were found in Regions 2, 4, 5, and 8. No data was submitted in the following areas: Primary Care Centers were not included in the report. Vision Providers – Coventry did not submit reports. Radiologists were not broken out by specialty in Coventry's Geo-Access reports. Specialist access was 100% for all regions; data was	explanation.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			reported in the aggregate of all specialists. Laboratories – Coventry did not submit reports. **Recommendation to CoventryCares of Kentucky** It is recommended that Coventry report non-physician providers by type and report access to vision providers. Identified gaps in access should be addressed by Coventry. **Final Review Determination** No change in review determination. Regarding the MCO's response: - Hospitals: see findings for prior element for hospital access on pages 7-8. - Pharmacy: see findings for prior element for pharmacy access on page 10. - Laboratory: see findings for prior element for lab access on pages 9-10. - Vision: see findings for prior element for access to vision services on page 10.	
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Full-2014	Full	This requirement is addressed in the Provider Access and Availability Policy and in the Availability of Practitioners Policy.	
29.10 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within 15 business	Full-2013	Full	Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Members shall not be included in the assessment as to whether the Contractor's Network is adequate to comply with access standard. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.			Recruitment, Network Shortage Policy. Report 13 for Quarter 3 indicates that no formal provider complaints or formal member complaints were made during the third quarter of 2015 to report issues related to access.	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Full-2013	Full	This requirement is addressed in the Provider Recruitment, Network Shortage Policy.	
31.1 Medicaid Covered Services				
The Contractor shall provide Covered Services in an the amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The contractor may establishing measures that are	Full-2013	Full	This requirement is addressed in the Member Handbook.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.				
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix H shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Full-2013	Full	This requirement is addressed in the Continuity and Coordination of Care Policy.	
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full-2013	Full	This requirement is addressed in the Provider Manual. Coventry is not in the practice of arranging or providing services that are in addition to those described above.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.	Full-2013	Full	This requirement is addressed in the Family Planning Services and Treatment for Sexually Transmitted Diseases Policy.	
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full-2013	Full	This requirement is addressed in the Prior Authorization Review Policy.	
33.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a	Full-2013	Full	This requirement is addressed in the	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).			Emergency and Post Stabilization Service Policy and the Assessing Appointment Availability Policy. This requirement is communicated to the members in the Member Handbook.	
33.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Full-2013	Full	This requirement is addressed in the Emergency and Post Stabilization Service Policy.	
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Full-2013	Full	This requirement is addressed in the Emergency and Post Stabilization Service Policy and in the Claims Processing Policy.	
31.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in this contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Full-2013	Full	This requirement is addressed in the Member Handbook and in the Direct Access to Services Policy.	
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full-2015	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
D. Maternity care for Members under 18 years of age;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
E. Immunizations to Members under 21 years of age;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
G. Tuberculosis screening, evaluation and treatment;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
I. Chiropractic services; and	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Handbook.	
J. Women's health specialists.	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy and in the Member Handbook.	
33.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix H to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.	Full-2013	Full	This requirement is addressed in Direct Access to Services Policy, the Family Planning Services and Treatment for Sexually Transmitted Diseases Policy and in the Member Handbook.	
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members less than eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.	Full-2013	Full	This requirement is addressed in the Notice of Privacy Policy. This requirement is also addressed in the Member Handbook.	
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's	Minimal - The requirement that all information be provided to members in a confidential manner is found in the Member Handbook and the Provider Manual. Missing from the documentation was the regulatory language pertaining	Minimal	The requirement that all information be provided to members in a confidential manner is found in the Member Handbook and the Provider Manual. Missing from the documentation is the regulatory language pertaining to counseling and medical services. **<u>Recommendation for CoventryCares of</u>**	Will agree to add language

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
privacy.	to counseling and medical services. Onsite, Coventry added the missing regulatory language to its Family Planning Services and Treatment for Sexually Transmitted Diseases Policy. **Recommendation for CoventryCares:** Coventry should add the regulatory language pertaining to counseling and medical service appointments to its Provider Manual and Member Handbook. **MCO Response:** Coventry will add the regulatory language pertaining to counseling and medical service appointments to its Provider Manual and Member Handbook for 2015.		**Kentucky** It is recommended that Coventry add the regulatory language to its Family Planning Services Policy and to its Provider Manual and Member Handbook. **Final Review Determination** No change in review determination.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	61	2	2	2
Total Points	183	4	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.82**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

- PCP responsibilities
- Provider hours of operation and availability, including after-hours availability
- Provider program capacity requirements
- Access and availability standards
- Emergency care, urgent care and post stabilization care
- Out-of-network emergency care
- Direct access services
- Voluntary family planning
- Referral for non-covered services
- Referral and assistance with scheduling for specialty health care services

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability
Process for monitoring of provider compliance with PCP responsibilities
Process for addressing non-emergent ER visits
Sample provider contracts – one per provider type
Provider Manual
Benefit Summary (covered/non-covered services)
Corrective action plan submitted to DMS for inadequate access, if applicable

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Provider access and availability reports
Geo Access network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care
- Behavioral health services including mental health and substance abuse providers

Final Findings

- Emergency care
- Hospital care
- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

Access and delivery network narrative reports (MCO Report #13)
Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring
Evidence of evaluation, analysis and follow-up related to non-emergent ER visits

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
21.0 Utilization Management				
21.1 Medical Necessity				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Introduction, page 1.	
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Utilization Management Program Oversight, page 8.	
The description shall include the scope of the program;	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Program Purpose, page 1.	
the processes and information sources used to determine service coverage;	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Program Objectives, pages 3 & 5.	
clinical necessity, appropriateness and effectiveness;	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Program Scope, page 6.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Full-2014	Full	This requirement is addressed in the UM Program Description 2015, Program Objectives, page5.	
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Utilization	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program.			Management Department, page 20.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Program Structure, Utilization Management Plan, page 7, and in the Annual Evaluation of 2014 Utilization Management Program.	
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Annual Utilization Management Work plan and Annual Utilization Management Program Evaluation, page 7.	
21.2 National Standards for Medical Necessity Review				
The Contractor shall adopt Interqual or Milliman for Medical Necessity; however, the contractor shall adopt the following standardized tools for medical necessity determinations for behavioral health -- for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII); for substance use: American Society of Addiction Medicine (ASAM).	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Utilization Management Tools, Criteria, page 22, and in UM_Chapter 8 (which describes behavioral health standardized tools). CoventryCares provided an example of MHNet behavioral health denials to cite evidence of tools that were used to help craft denial decision (e.g., ASAM,CALOCUS, LOCUS).	
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Quality Management/ Utilization Management Committee, Major Responsibilities, page 10.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description 2015, Utilization Management Department, page 18-19. <u>UM File Review Results</u> 10 adult files and 5 EPSDT files were reviewed. Clinical criteria were collected as appropriate for all files.	
The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description 2015, Utilization Management Department, page 20. BH Director provided her job description which cites supervision of internal programs, and also submitted organizational flow chart, which showed evidence of BH director working directly beneath Medical Director to oversee all healthcare staff. <u>UM File Review Results</u> 10 adult files and 5 EPSDT files were reviewed. All denials were made by a physician with appropriate clinical expertise.	
The reason for the denial shall be cited.	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description 2015, Utilization Management Department, page 20.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All included reasons for denials.	
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Utilization Management Department, page 19.	
The Medical Necessity review process shall be completed within 2 business days of receiving the request and shall include a provision for expedited reviews in urgent decisions.	Full-2013	Full	Included UM file review results This requirement is addressed in the UM Program Description 2015, Decision/Notification Requirements table, page 26. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files had evidence of timely (2 day) review.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Full-2013	Full	This requirement is addressed in Policy UM-038.	
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-2013	Full	This requirement is addressed in MHN Contract, Section 2, Obligations of Subsidiary Plan or Payer, 2.11. Provider Manual, page 6. The requirement of a mechanism to ensure consistent application of review criteria for authorization decisions is addressed in Report #59 2015, Prior Authorizations, Medical Management.	
C. In the event that a Member or Provider requests	Full-2013	Full	This requirement is addressed in the UM	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
written confirmation of an approval, the Contractor shall provide written confirmation of its decision within 3 working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.			Program Description 2015, Notice of Requirements, page 22.	
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Utilization Tools, Clinical Practice Guidelines, page 24.	
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.	Full-2013	Full	This requirement is addressed in the UM Program Description 2015, Prior Authorization, page 24.	
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.	Full-2013	Full	This requirement is addressed in MHN Contract, Section 6, Books and Records, 6.7 Physician Incentive Plans Information, page 16.	
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Full-2014	Full	This requirement is addressed in the UM Program Description 2015, Utilization/Performance Improvement Indicators, page 36-37.	
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Utilization Management Tools, page 22-23.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the process used to review and approve the provision of medical services.				
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Member, Practitioner and Provider Satisfaction Surveys, page 39.	
The UM program will be evaluated by the Department on an annual basis.	Full-2013	Full	Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results). This requirement is addressed in the UM Program Description, 2015, Annual Utilization Management Program Evaluation, page 7 and Report #59 (Q4 2015 results were not reviewed since they were not available at the time of the compliance review).	
21.3 Adverse Actions Related to Requests for Services and Coverage Denials				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any adverse Action (not just service authorization actions) within the timeframes for each type of Action pursuant to 42 CFR 438.210(c). The notice must explain:	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, pages 21-22.	
A. The action the Contractor has taken or intends to take;	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Requirements, page 21. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files had documentation citing the decision.	
B. The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 21. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files had reasons for denials that were easily understandable. In instances where complex medical language was cited, it was either elaborated upon, or the member was encouraged to speak further with their provider.	
C. The federal or state regulation supporting the action, if applicable;	Full-2015	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 21. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files contained federal/state regulations supporting the denial.	
D. The Member's right to appeal;	Full-2013	Full	Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files included member's right to appeal.	
E. The Member's right to request a State hearing;	Full-2014	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files included member's right to a state hearing.	
F. Procedures for exercising Member's rights to Appeal or file a Grievance;	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files included member's rights to appeal or file a grievance, and procedures for doing so.	
G. Circumstances under which expedited resolution is available and how to request it;	Full-2013	Full	Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files cited expedited resolution and how a member could request it.	
H. The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Full-2015	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files contained language that stated member has right to benefits pending resolution of the appeal, and the circumstances under which they may be required to pay costs of services.	
I. Be available in the state-established prevalent non-English languages in its service area;	New Requirement	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 22. UM File Review Results 10 adult files and 5 EPSDT files were reviewed. All files had evidence that results of UM decision could be made available in Spanish or	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			other language.	
J. Be available in alternative formats for persons with special needs; and	New Requirement	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 21. <u>UM File Review Results</u> 10 adult files and 5 EPSDT files were reviewed. All files had language stating that UM denial could be available in TTY for those with special needs.	
K. Be easily understood in language and format.	New Requirement	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, page 21.	
The Contractor must give notice at least: A. Ten (10) days before the date of an adverse Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
B. The Contractor must give notice by the date of the adverse Action for the following:				
1. In the death of a Member;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
3. The Member's admission to an institution where he is ineligible for further services;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
6. The Member's physician prescribes the change in the level of medical care;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 28.	
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.			Reduction of Services, page 28.	
C. The Contractor must give notice on the date of the adverse Action when the Action is a denial of payment.	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Extension of Decision Times for Non-Urgent Pre-Service Decisions, page 26.	
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Extension of Decision Times for Non-Urgent Pre-service Decisions, page 26. <u>UM File Review Results</u> 10 adult files and 5 EPSDT files were reviewed. An extension was granted for 2 of the 10 adult files, in which case the 14 day timeframe for a decision was met. For the other 8 adult files and 5 EPSDT files, the timeliness standard of 2 days was met.	
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension	Full-2013	Full	Includes UM file review results This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Termination, Suspension, or Reduction of Services, page 26-27. <u>UM File Review Results</u>	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
expires.			10 adult files and 5 EPSDT files were reviewed. For the 2 members who had extension, documentation was provided that had evidence member was made aware of the extension, and their right to file a grievance if they disagree with that decision.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Decision/Notification Requirements (table), page 25.	
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.	Full-2013	Full	This requirement is addressed in the UM Program Description, 2015, Notice of Action Requirements, Extension of Decision Times for Non-Urgent Pre-Service Decisions, page 27.	
21.4 Prior Authorizations				
The Department on or by January 1, 2016, shall approve a Prior Authorization Form for all participating MCOs, which shall be used by the Contractor to initiate its prior authorization process.	New Requirement	Full	This requirement is addressed in the prior authorization form, approved by DMS, located on Aetna's website.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	53	0	0	0
Total Points	159	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
Suggested Evidence

Documents

Policies/procedures for:

- Utilization management
- Review and adoption of medical necessity criteria
- Monitoring to ensure clinically appropriate overall continuity of care
- Incorporation of prior authorization data into QI plan

UM Program Description
Contracts with any subcontractors delegated for UM
Evidence of provider involvement in the review and adoption of medical necessity criteria
UM Committee description and minutes
Process for detecting under-utilization and over-utilization of services
Sample letter for notice of action

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
Prior Authorizations (MCO Report #59)

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
37.0 Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix N, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to 6 months to provide a new or revised program. This plan shall include, at a minimum:	Full-2013	Substantial	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3. Missing from the policy is the language that "the Contractor shall have up to 6 months to provide a new or revised program." **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry add language to a policy or procedural document that addresses the requirement that the Contractor has up to six (6) months to provide a new or revised program.	
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3.	

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, Opening paragraph, page 2.	
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3.	
D. Effective lines of communication between the compliance officer and the organization's employees;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3.	
E. Enforcement of standards through disciplinary guidelines;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3.	
F. Provision for internal monitoring and auditing of the member and provider;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity, page 3, C. Prohibited Affiliations, page 3, and D. Verification of Services for Members, page 3-4.	
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, B. Program Integrity,	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			page 3.	
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, I. Program Integrity-General Obligations for Medicaid Health Plans, C. Prohibited Affiliations, page 3.	
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, G. Auditing, page 21.	
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the Department;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan for CoventryCares of Kentucky, C. Detection/Prevention, Identifying Persons and Organizations Involved in Suspicious Claims or Eligibility Activity, Medical Claims (i.e. claims processed through IDX), pages 8-9. Providing monthly reports of activity and collections to the Department is found in this same policy, E. Reporting Fraud and Abuse, page 20.	
K. Contractor shall provide procedures for appeal process;	Full-2013	Full	This requirement is addressed in the Member Grievance and Appeals Policies.	
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2013	Full	This requirement is addressed in MCO Report #73, EOMB.	
M. Contractor shall create a process for card sharing	Full-2013	Full	This requirement is addressed in Program	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
cases;			Integrity Policy, Procedure: 5. Guidelines and Procedures for Detecting Fraud, (c) Member Fraud, page 3.	
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;	Full-2013	Full	Includes review of MCO Report #75 SUR Algorithms This requirement is addressed in Report #75 SUR Algorithms, Desk Report. Report #75 provides evidence that Coventry runs algorithms on Claims data and reports these findings, including issues identified and actions taken to the Department.	
O. Contractor shall follow cases from the time they are opened until they are closed; and	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, D. Investigations, Investigative Process, Initial Handling of Referral, page 12. By placing referral in the SIU Case Tracking Database, Contractor has access to case.	
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, B. Education/Training, Employee Education/Training, page 4.	
The plan shall be made available to the Department for review and approval.	Full-2013	Full	This requirement is addressed in Coventry Health Care Compliance and Ethics Program under the Federal and State Reporting Exhibit.	
9.2 Administration/Staffing				

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the Contractor's enrollment or projected enrollment.				
P. A Compliance Director who shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractors and oversee the Contractor's compliance with the laws and requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.	Full-2013	Full	This requirement is addressed in the Code of Business Conduct and Ethics Policy, IX. Implementation, C. Training, page 18.	
N. A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.	Full-2013	Full	This requirement is addressed in the Program Integrity Policy (COM-003) Procedure: 2. Primary Contact Person, page, 1-2. According to this policy, the role of the Program Integrity Coordinator is held within the role of the Compliance Officer.	-
38.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS,	Full-2014	Minimal	Includes review of individual disclosures This requirement is found in the "Revised Annual Disclosure of Ownership Instructions."	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:			However, there is no policy provided by the plan that addresses provisions (1)-(5) explicitly. <u>Individual Disclosure Review</u> CoventryCares of Kentucky and all subcontractors (14 subcontractors) who provide services related to claim and/or payment review, Utilization Management (UM) functions, coordination of benefits (COB), or provide services directly to members (e.g., dental, vision) were reviewed for submission of disclosure forms to Coventry; registration with Kentucky Secretary of State (SOS); and exclusion per the DHHS Office of the Inspector General (OIG) and the US government System for Award Management (SAM) Excluded Parties List System (EPLS). Coventry Health Care and Coventry Health and Life Insurance Company and their respective officers were registered on the KY SOS website. Three (3) of the fourteen (14) subcontractors that were registered did not have officers listed: Akorbi Translations, National Research Corporation, and Prest and Associates. The remaining 11 subcontractors' officers were registered on the KY SOS website. A disclosure of ownership form for Coventry	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			was provided. Annual Disclosure forms were not submitted for the MCO's subcontrators. **Recommendation to CoventryCares of Kentucky** It is recommended that Coventry explicitly add the regulatory provisions to its policy. Coventry should ensure that all applicable subcontractors are registered with the Kentucky SOS; that all registered contractors have officers registered/listed on the website; and that the MCO obtains disclosure of ownership forms from all applicable subcontractors.	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;	Full-2014	Minimal	Includes review of individual disclosures This requirement is addressed in the Revised Annual Disclosure of Ownership Instructions, in definition: Person with an ownership or control interest, page 1. In instruction #8, page 1, the Contractor or Subcontractor must specify the relationship of any family member. Individual Disclosures Review Coventry did not provide disclosure of ownership forms for review for its 14 subcontractors. The Coventry (Aetna Holdings Corp.) disclosure of ownership form was submitted for review.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for CoventryCares of Kentucky Coventry should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures and must be dated.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Full-2014	Minimal	Includes review of individual disclosures This requirement is addressed in the Revised Annual Disclosure of Ownership Instructions, in definition: Other Disclosing Entity, page 1. Individual Disclosures Review Coventry did not provide disclosure of ownership forms that provide the name of any entity receiving reimbursement through the Medicare or Medicaid programs. **Recommendation for CoventryCares of Kentucky** Coventry should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated.	
C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Full-2013	Minimal	Includes review of individual disclosures This requirement is addressed in the Revised Annual Disclosure of Ownership Instructions, in definition: Significant Business Transaction,	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			page 1. Individual Disclosures Review Coventry did not provide disclosure of ownership forms that provide the name of any entity with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period. **Recommendation for CoventryCares of Kentucky** Coventry should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated.	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	Full-2013	Minimal	Includes review of individual disclosures This requirement is addressed in the Revised Annual Disclosure of Ownership Instructions, in definition: Significant Business Transaction, #12, page 1. Individual Disclosures Review Coventry did not provide disclosure of ownership forms which would contain a description of any significant business transactions between the Contractor and supplier, or between Contractor and any Subcontractor, during the preceding five-year period.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for CoventryCares of Kentucky Coventry should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated.	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Full-2014	Minimal	Includes review of individual disclosures This requirement is addressed in the Revised Annual Disclosure of Ownership Instructions, in definition: Significant Business Transaction, #14, page 1. Individual Disclosures Review Coventry did not provide disclosure of ownership forms that provide the identity of any person who has an ownership or control interest and has been convicted of a criminal offense. **Recommendation for CoventryCares of Kentucky** Coventry should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated.	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any	Full-2015	Full	This requirement is addressed in the Code of Business Conduct and Ethics Policy, B. Outside Financial Interests, page 6.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and				
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.	Full-2013	Full	This requirement is addressed in the Program Integrity Plan.	
State Contract, Appendix N				
ORGANIZATION: The Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;	Full-2013	Full	This requirement is addressed in the Program Integrity Policy (COM-003), Policy, page 1.	
B. Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;	Full-2013	Full	This requirement is addressed in the Program Integrity Policy (COM-003), Procedure: 4. Monitoring Tools and Controls, page 2 and 5. Guidelines and Procedures for Detecting Fraud, page 3.	
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with Federal and State requirements;	Full-2013	Full	This requirement is addressed in the Fraud Plan Revision, II. Policy, page 1.	

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2013	Full	This requirement is addressed in the SIU Organization Chart and Job Description. However, the SIU Sr Analyst job description best fits the role of auditor, page 19. Pg. 23 contains the job description of Special Investigation Unit Review Nurse.	
E. The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	Non-Compliance - The documentation provided does not meet the requirement. The plan does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national. During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) prioritizes membership /patient harms issues but no formal policy exists. **DMS Response:** In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with for the 2015 review. DMS has concerns. **MCO Response:** Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.	Full	This requirement is addressed in Kentucky SIU Policy and Procedure 11/25/2015, Procedure, page 2. This is addressed in the Policy SIU Medical Case Process, attachment Risk Assessment Process. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry add language to its policy that addresses cases involving multi-state fraud or problems of national scope, fraud or abuse crossing partnership boundaries, and high dollar amount of potential overpayments.	-

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy. A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address prioritization of cases for investigation. No documentation to address prioritization of cases based on "Allegations or cases having the greatest program impact" was provided. Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Non-Compliance – See Above.	Full	This is addressed in the Policy SIU Medical Case Process, attachment Risk Assessment Process.	
(2) High dollar amount of potential overpayment; or	Non-Compliance – See Above.	Full	This is addressed in the Policy SIU Medical Case Process, attachment Risk Assessment Process.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Non-Compliance – See Above.	Full	This requirement is addressed in the Identifying, Reporting, and Addressing Abusive/Fraudulent Behavior by Providers Procedure, A. Identification of Fraud/Abuse, c. Identification Pattern, page 3.	
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2013	Full	This requirement is addressed in the 2013 Program Integrity Plan, C. Detection/ Prevention, Identifying Persons and Organizations Involved in Suspicious Claims or Eligibility Activity, page 7.	
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013	Full	This requirement is addressed in the Code of Business and Conduct, IX. Implementation, C. Training, page 18.	
FUNCTION: Contractor and/or Contractor's PIU shall:				
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Full-2013	Full	The requirement pertaining to recoupment of overpayments is addressed on page 3 of the Program Integrity Policy. Changes to the policy are addressed in the CHC Policy on Employee Training on page 2. Dispute resolution is addressed in the KY SIU Policy and appeals information is evidenced in the Code of Business Conduct and Ethics, G. Procedures, #3, page 23.	
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and	Full-2013	Full	This requirement is addressed in Report #75 SUR Algorithms, Desk Report and in the Identifying FWA policy, Procedure: A.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
record reviews;			Identification of Fraud/Waste, b. Corroboration, page 3.	
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2013	Full	This requirement is addressed in Identifying FWA policy, Procedure: A. Identification of Fraud/Waste, b. Corroboration, page 3.	
D. Initiate appropriate administrative actions to collect overpayments;	Full-2013	Full	This requirement is addressed in Identifying FWA policy, Procedure: B. Corrective Action, 1. Corrective Action Options a-e, page 4.	
E. Refer potential Fraud, Waste and Abuse cases to the OIG with copy to the Department for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;	Full-2013	Full	This requirement is partially addressed in the CHC Policy on Federal and State Government Agency Requests for Information, Audits, Interviews, Searches and Other Contacts with CHC Regarding CHC or its Affiliates, III. Administrative Issues, A., page 3. This requirement is partially addressed in the Procedure for Identifying, Reporting, and Addressing Abusive/Fraudulent Behavior by Providers, C. Reporting, page 5.	
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan.	
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full-2013	Full	This requirement is addressed in the Fraud Plan Revision, II. Policy, page 1.	

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Full-2013	Full	This requirement is addressed in the Procedure for Identifying, Reporting, and Addressing Abusive/Fraudulent Behavior by Providers, B. Corrective Action, 1. Corrective Actions Option, a-e, page 4.	
I. Provide for internal monitoring and auditing of Contractor and it subcontractors; and supply the Department with reports on a quarterly basis or as-requested basis on its activity and ad hocs as necessary;	Full-2014	Full	This requirement is addressed in Submission-PIU Monitoring, Quarterly Data Mining, page 1.	
J. Be subject to on-site review and fully comply with requests from the Department to supply documentation and records;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013 Update, G. Auditing, page 21.	
K. Create an accounts receivable process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the Department;	Full-2013	Full	Includes review of MCO Report #71 Provider Outstanding Account Receivables This requirement is addressed in Submission-PIU Monitoring, Data Mining Monthly meeting, page1. Report #71 provides evidence that Coventry has a process to collect outstanding debt from members and providers and has monthly reports of activity.	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	Non-Compliance - The documentation provided does not meet the requirement.	Non-Compliance	No documentation was provided by the plan that satisfies this requirement. Missing from the documentation is language in a policy that states that Coventry allows the Department to collect and retain any overpayments if the	**MCO Response** We will update our policy with this language.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			plan has not taken appropriate action to collect after 180 days. **Final Review Determination** No change in review determination.	
M. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013 Update, D. Investigations, Investigative Process, Evaluating the Referral, page 12.	
N. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;	Full-2013	Full	This requirement is partially addressed in the Program Integrity Plan 2013 Update, C. Detection/Prevention, Medical Claims, 1st paragraph, page 9. This requirement is partially addressed Submission-PIU Monitoring, Quarterly Data Mining, page1.	
O. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Full-2013	Full	This requirement is addressed in the Program Integrity 2013 Update, C. Detection/ Prevention, Role of Pharmacy Vendor (Vendor Audit Function/Vendor SIU), page 8. Provider Outstanding Account Receivable documentation provided evidence of auditing conducted by Coventry to identify overpayments.	
P. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Full-2013	Full	This requirement is addressed in the Program Integrity 2013 Update, G. Auditing, page 21.	
Q. Designate a contact person to work with investigators and attorneys from the Department	Full-2013	Full	This requirement is addressed in Program Integrity, Procedure: 2. Primary Contact	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and OIG;			Person, page 1.	
R. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Full-2013	Full	This requirement is addressed in the CHC Policy of Reporting of Potential Issues or Areas of Noncompliance, I. Duty to Report and Compliance Officer Investigations, page 1.	
S. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2013	Full	Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB) This requirement is addressed in MCO Report #73, EOMB.	
T. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;	Full-2013	Full	Includes review of MCO Report #75 SUR Algorithms This requirement is addressed in Submission-PIU Monitoring, Quarterly Data Mining, page1.	
U. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Full-2013	Non-Compliance	No documentation was provided by the plan that satisfies this requirement. Missing from the documentation is language in a policy or procedure that the plan can collect from member's overpayments that were declined prosecution for Medicaid Program Violations. **Final Review Determination** No change in review determination.	**MCO Response** We will update our policy with this language

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
V. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review and approval;	Full-2013	Full	This requirement is addressed in the 2013 Program Integrity Update, page 1.	
W. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Full-2014	Non-Compliance	No documentation was provided by the plan that satisfies this requirement. Missing from the documentation is language in a policy or procedure that Coventry reports to the Department any provider denied enrollment within 5 days of denial.	
X. Recover overpayments from providers and identify Providers for pre-payment review as a result of the Provider's activities;	Full-2013	Full	This requirement is addressed in the Procedure: Identifying, Reporting, And Addressing Abusive/Fraudulent Behavior by Providers, B. Corrective Action, 1. Correction Action Options, d., page 4.	
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Full-2013	Full	This requirement is addressed in the Procedure: Identifying, Reporting, And Addressing Abusive/Fraudulent Behavior by Providers, C. Reporting, 1., State Reporting, and 2. Federal Reporting, page 5	
Z. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by	Full-2013	Full	This requirement is addressed in the Identifying Fraud, Waste, and Abuse Exhibit 4 as well as in the Reporting Policy Exhibit 1A.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Federal and state laws and regulations.				
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG.	Non-Compliance - The Program Integrity Plan states that cases involving member safety (abuse) are reported to the health plan medical director for review. Policy and Procedure COM-001 Compliance Committee states that the roles and responsibilities of the Compliance Committee include timely and consistent communication with the Department's Program Integrity Unit, AG MFCU, OIG and reporting to the Department and OIG immediately any suspicion/knowledge of fraud or abuse. This does not specifically address patient abuse and does not address reporting to DCBS. **DMS Response:** In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with 2015 review. DMS has concern. **MCO Response:** Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases. **Final Review Determination:** No change in	Full	This requirement is addressed in the Reporting Alleged Child Abuse or Neglect Policy on page 1 and in the Reporting Alleged Adult Abuse or Neglect Policy on page 1.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	review determination. Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of patient abuse in this Policy. A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address reporting patient abuse. There are general statements regarding referrals to law enforcement and governmental agencies. Additionally, "abuse" is this document is defined only related to payment. The Program Integrity Plan 2013 was submitted on 3/17/15. This document contains the same statement regarding reporting cases involving member's health or safety to the Medical Director. This document also addresses routine, monthly reporting to the State. The related Exhibit 2 Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide indicates only generally SIU reporting to a governmental agency. Abuse is referenced only in terms of payment in this Plan and the Exhibits. Coventry did not submit any Policy or document that includes the language "If the			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps." Policies and Procedures CM-033 and CM-034 were submitted by Coventry for the Case Management review domain. These Policies were not referenced in relation to Program Integrity; therefore, they were not reviewed. Also note that these Policies do not address reporting to the Department and/or OIG. Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.			
COMPLAINT SYSTEM: The Contractor's PIU shall operate a system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;	Full-2013	Full	This requirement is addressed in the 2013 Program Integrity Update, D. Investigations, Investigative Process, Initial Handling of Referral, page 12.	
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Full-2013	Full	This requirement is addressed in the Program Integrity Policy.	
C. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Full-2013	Full	This requirement is addressed in the Program Integrity 2013 Update, D. Investigations, Closing the Investigation, page 16.	
D. If the preliminary inquiry results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the OIG, with a copy to the Department;	Full-2013	Full	This requirement is addressed in the Program Integrity 2013 Update, D. Investigations, Closing the Investigation, page 16.	
E. OIG will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;	Full-2013	Full	This requirement is addressed on page 2 of the Program Integrity Policy.	
F. If in the process of conducting a preliminary review, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the OIG with a copy to the Department of their findings and proceed only in accordance with instructions	Full-2013	Full	This requirement is addressed on page 2 of the Program Integrity Policy.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
received from the OIG;				
G. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report and forward information to the Department, the PIU, or, if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate actions;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;	Full-2013	Full	This requirement is addressed throughout the Program Integrity Plan.	
K. Upon completion of the PIU's preliminary review, the PIU shall provide the Department and the OIG a copy of their investigative report, which shall contain the following elements:	Full-2014	Full	This requirement is addressed in both Report #77 and Report #76 Sample Layouts.	

MCO: CoventryCares of Kentucky

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(1) Name and address of subject,	Full-2013	Full	Includes Program Integrity file review results This requirement is addressed in Report #77 Member Fraud Waste and Abuse, Sample Layout and Report # 76 Provider Fraud Waste and Abuse, Sample Layout. Program Integrity File Review Results 10 files were reviewed in total – 5 provider files and 5 member files 10/10 files contained the name and address of the subject of the investigation	-
(2) Medicaid identification number,	Full-2013	Full	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 10/10 files contained the Medicaid identification number.	
(3) Source of complaint,	Full-2013	Full	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 10/10 files contained the source of the complaint.	
(4) State the complaint/allegation,	Full-2013	Full	Includes Program Integrity file review results	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 10/10 files contain the complaint and/or allegation	
(5) Date assigned to the investigator,	Full-2013	Full	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 10/10 files contain the date the case was assigned to the investigator.	
(6) Name of investigator,	Full-2013	Full	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 10/10 files contain the name of the investigator.	-
(7) Date of completion,	Full-2013	Substantial	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 7/10 files contain the date of completion.	**MCO Response** We will take into considerations the recommendations. Through migration, we will update our process with our vendors to strengthen the communication between the vendor and the plan to ensure all policies and procedure are in line with one another.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			2/10 files did not contain the date of completion due to incomplete investigation. On one of these files Coventry reported difficulties in receiving information from Avesis. 1/10 files was in an active investigation at the time of the review. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine the way it investigates and completes files and develop methodology to improve its communication with Avesis. **Final Review Determination** No change in review determination.	
(8) Methodology used during investigation,	Full-2013	Substantial	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 9/10 files contain the methodology used during the investigation. 1/10 files was missing the methodology. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its procedure to make certain that all files	**MCO Response** CoventryCares and Aetna will use the same methodology on all cases going forward and document as such.

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			contain evidence of the methodology used during each investigation.	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full-2013	Substantial	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 8/10 files contain the facts discovered by the investigation as well as the full case report and supporting documentation. 2/10 files had incomplete facts, case reports, and supporting documentation. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its procedures to make certain that all files contain a full case report and supporting documentation as well as facts discovered during the investigation. **Final Review Determination** No change in review determination.	**MCO Response** Of the 10 files: Two files are still open and ongoing. As the cases come to closure, we will include a full case report with supporting documentation and facts discovered during the investigation.
(10) Attach all exhibits or supporting documentation,	Full-2013	Substantial	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts.	**MCO Response** Two files are still open and ongoing. As the cases come to closure, we will include a full case report with supporting documentation and facts discovered during the

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Program Integrity File Review Results 8/10 files contain the facts discovered by the investigation as well as the full case report and supporting documentation. 2/10 files had incomplete facts, case reports, and supporting documentation. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its procedures to make certain that all files contain exhibits and supporting documentation. **Final Review Determination** No change in review determination.	investigation.
(11) Include recommendations as considered necessary, for administrative action or policy revision,	Full-2013	Substantial	Includes Program Integrity file review results This requirement is addressed in the Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide, SIU INVESTIGATIVE PROCESS, page 5. Program Integrity File Review Results 2/10 files included recommendations for administrative action or policy revision. 2/10 files did not address this element due to inadequate investigation. 6/10 files did not warrant recommendations and were assigned a designation of 'Not	**MCO Response** Two files are still open and ongoing. As the cases come to closure, we will include a full case report with supporting documentation and facts discovered during the investigation.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Applicable' for this requirement. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its procedures to make certain that all files contain thorough investigations. **Final Review Determination** No change in review determination.	
(12) Identify overpayment, if any, and recommendation concerning collection,	NA - No cases presented for overpayment.	Substantial	Includes Program Integrity file review results This requirement is addressed in both Report #77 and Report #76 Sample Layouts. Program Integrity File Review Results 1/10 files identified an overpayment and contained a recommendation concerning collection. 2/10 files did not contain enough information due to incomplete investigations. 7/10 files did not identify an overpayment. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine its procedures to make certain that all files contain thorough investigations. **Final Review Determination**	**MCO Response** Two files are still open and ongoing. As the cases come to closure, we will include a full case report with supporting documentation and facts discovered during the investigation.

MCO: CoventryCares of Kentucky

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			No change in review determination.	
(13) Any other elements identified by CMS for fraud referral;	Non-Compliance - The documentation provided does not meet the requirement.	Full	This requirement is addressed in both Report #77 and Report #76 Sample Layouts as well as in Identifying FWA Policy Exhibit 4.	
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Full-2013	Full	Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report This requirement is addressed in the Reports 76 and 77 wherein there is evidence that Coventry's PIU provides a quarterly member and provider status report of all cases to the Department.	
M. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and	Full-2013	Full	This requirement is addressed in the Program Integrity Plan.	
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2013	Full	This requirement is addressed in Coventry's Grievance and Appeals Policies for both Members and Providers. Members are made aware of their right to file a grievance or appeal in the Member Handbook. This requirement is communicated to providers in the Provider Manual.	
REPORTING: The Contractor's PIU shall report on a quarterly basis in a narrative report format all activities and	Full-2013	Full	Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
processes for each investigative case (from opening to closure) to the Department. If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.			The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts. The requirement of reporting any suspected violations to the PIU Coordinator is addressed in the CHC Policy on Reporting of Potential Issues or Areas of Noncompliance, I. Duty to Report and Compliance Officer Investigations, page 1.	
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(1) PIU Case number;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(2) OIG Case number (if one has been assigned);	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(3) Provider/Member name;	Full-2014	Full	Includes review of MCO Report #76 and	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(4) Provider/Member number;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(5) Date complaint received by Contractor;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2014	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(7) Date opened and name of PIU investigator assigned;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(8) Summary of complaint;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	Full-2014	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(10) PIU action taken and date (only provide the most current update);	Full-2014	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(11) Amount of overpayment (if any) and time span;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Report #76 Sample Layouts.	
(13) The overpayment required to be repaid and overpayment collected to date;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(14) Describe sanctions/withholds applied to Providers/Members, if any;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(15) Provider/Members appeal regarding overpayment or requested sanctions. List the date an appeal was requested, date the hearing was held, the date and decision of the final order;	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(16) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented revision and date of implementation; and	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly basis is addressed in both Report #77 and Report #76 Sample Layouts.	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2013	Full	Includes review of MCO Report #76 and Report #77 The requirement of reporting on a quarterly	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			basis is addressed in both Report #77 and Report #76 Sample Layouts.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Full-2015 - This requirement is addressed in the Records Retention and Destruction Procedures.	Full	This requirement is addressed in the Records Retention and Destruction Procedures.	
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2013	Full	This requirement is addressed in the following documentation: the Program Integrity Plan, the Availability of Providers Policy, the Selection and Retention of Network and in the Provider Recruitment and Network Shortage Policy.	
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan Auditing, page 22.	
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or the OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan Auditing, page 21-22.	

MCO: CoventryCares of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, G. Auditing, page 21-22.	
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, G. Auditing, page 21-22.	
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, G. Auditing, page 21-22.	
H. Fully cooperate with the Department, the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Full-2013	Full	This requirement is addressed in the Program Integrity Plan 2013, G. Auditing, page 21-22.	
I. Provide identity and cover documents and information for law enforcement investigators under cover.	New Requirement	Non-compliant	No documentation was provided by the plan that satisfies this requirement	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015

MCO: CoventryCares of Kentucky

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Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	100	7	6	4
Total Points	300	14	6	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.74**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

- post payment audits
- internal monitoring and auditing
- preventive actions
- annual ownership and financial disclosure

Program Integrity Plan including related policies and procedures
Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members
Program Integrity Unit description including Compliance Officer position description
Program Integrity Committee description and minutes
Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees
Provider contract provisions for FWA
Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
SUR Algorithms (MCO Report #75)
Quarterly Program Integrity Reports (MCO Reports #76 and 77)
Provider Outstanding Account Receivables (MCO Report #71)
Explanation of Member Benefits (MCO Report #73)

File Review

Program Integrity files for a random sample of cases chosen by EQRO
ADO files selected by EQRO

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix M. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Full-2013	Full	Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24 Addressed in policies and procedures: CM-028 EPSDT Program, CM-025 EPSDT Referral, CM-026 Transitioning Members who Age-out. Coventry submitted MCO Report #93 EPSDT CMS-416 which shows a screening rate of 56% and a participation rate of 53%. Coventry submitted MCO Report #24 Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death which describes activities to ensure and increase members' receipt of EPSDT services, which include, but are not limited to: hiring an EPSDT Coordinator/Quality Management Project Manager; an ehnaced outreach program to members for gaps in care; notifications to providers; coordination with the DCBS EPSDT Coordinator and plans to address chronic dental non-compliance.	

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MCO: CoventryCares of Kentucky

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Full-2013	Full	Addressed in policy and procedures CM-028 EPSDT Program and ND-003 Selection and Rentention of Network, and the Provider Manual, page 35.	
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.	Full-2014	Full	Addressed in policy and procedures CM-028 EPSDT Program and ND-003 Selection and Retention of Network and in the Provider Manual, page 35.	
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.	Full-2013	Full	Addressed in the 2015 Quality Management Program Description (QMPD) under Prevention and Wellness and in the 2015 QM Work Plan. Evidenced in the 2015 Prevention and Wellness Program, HEDIS/Healthy Kentuckinans Program, and 2015 Member Handbook, p 36 and the EPSDT Clinical Tracking System and MCO Report #24 Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.	
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.	Full-2014	Full	Includes file review results for EPSDT UM files and EPSDT Appeal files <u>EPSDT UM File Review Results</u> All files were fully compliant. <u>EPSDT Appeal File Review Results</u>	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			All files were fully compliant. Addressed in policy and procedure CM-028 EPSDT Program. Evidenced in the 2015 Prevention and Wellness Program, HEDIS/Healthy Kentuckinans Program, and 2015 Member Handbook, p 36 and the EPSDT Clinical Tracking System.	
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix M.	Full-2013	Full	Evidenced in the MCO Report #93 CMS-416 EPSDT Report and 2015 HEDIS results and in the EPSDT Clinical Tracking System.	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.	Full-2013	Full	Addressed in the 2015 Provider Manual on page 21 and pages 34-39.	
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Full-2013	Full	Addressed in the 2015 Provider Manual on page 21 and pages 34-39.	
F. Provide EPSDT Special Services for eligible members,	Full-2013	Full	Addressed in the 2015 Provider Manual on	

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix M.			page 21 and pages 34-39.	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	Full-2015	Full	Addressed in policy and procedure CM-028 EPSDT Program. Evidenced in the EPSDT Clinical Tracking System.	
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.	Full-2013	Full	Addressed in policy and procedure CM-028 EPSDT Program and the 2015 Prevention and Wellness Program. Evidenced in the EPSDT Clinical Tracking System, the 2015 QM Work Plan, and the 2015 HEDIS/Healthy Kentuckians/EPSDT/Foster Care Work Plan.	
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.	Full-2013	Full	Addressed in policy and procedure CM-028 EPSDT Program and the 2015 Prevention and Wellness Program. Evidenced in the EPSDT Clinical Tracking System.	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Full-2013	Full	Addressed in policy and procedure CM-028 EPSDT Program. Evidenced in the files reviewed for PH/BH coordination, care coordination, and complex care management.	
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.	New Requirement	Full	Addressed in policy and procedure CM-028 EPDST Program and CM-017 Care Management for Members with Special Health Care Needs, and CM-016 Case Management WIC Referral Process . The MCO indicated that coordination with other services is accomplished for individual members via the case manager and overall through the MCO liaisons' participation in the DCBS regional EPSDT Coordinator meetings and the Children's Heath Technical Advisory Committee meetings.	
K. Participate in any state or federally required chart audit or quality assurance study.	Full-2013	Full	Addressed in the 2015 QM Work Plan. Coventry has participated in the EQRO's annual EPSDT encounter validation studies and focused studies.	
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be	Full-2014	Full	Addressed in policy and procedure CM-028 EPSDT Program. Evidenced in the 2015 Provider Manual, Provider Newsletters and educational materials.	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.				
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.	Full-2013	Full	Addressed in policy and procedure CM-028 EPSDT Program and in the 2015 Provider Manual. Coventry submits encounter data monthly to DMS/the fiscal agent as required and the data is provided to IPRO by DMS/the fiscal agent. Coventry submitted MCO Report #93 EPSDT CMS-416 which shows a screening rate of 56% and a participation rate of 53%.	
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Full-2014	Full	Addressed in EPSDT Special Needs Coordinator job description. Coventry hired a new EPSDT Coordinator/Project Manager in Q4 2014, as documented in MCO Report #24, dated 1-30-2015. Evidenced in the Organizational Chart.	
23.1 Required Functions				
N. The Contractor's Member Services function shall also be responsible for: Arranging for and assisting with scheduling	Full-2014			

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.				
38.9 EPSDT Reports				
The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter File shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.	Full-2013	Full	Includes review of MCO Report #93 EPSDT CMS-416 Addressed in policy and procedure CM-028 EPSDT Program and in the 2015 Provider Manual. Coventry submits encounter data monthly to DMS/the fiscal agent as required and the data is provided to IPRO by DMS/the fiscal agent. Coventry submitted MCO Report #93 EPSDT CMS-416 which shows a screening rate of 56% and a participation rate of 53%.	

IPRO
Improving Healthcare for the Common Good

Final Findings

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	19	0	0	0
Total Points	57	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Suggested Evidence

Documents

Policies/procedures for:

- EPSDT services
- Identification of members requiring EPSDT special services
- Education/information program for health professionals
- EPSDT provider requirements
- Coordination of physical health services and behavioral health services
- Coordination of other services, e.g., early intervention services

EPSDT member/provider ratio and case management ratio for EPSDT children with special needs
Evidence of communication of required EPSDT information with eligible members and families
EPSDT Coordinator position description
Description of tracking system to monitor acceptance and refusal of EPSDT services
Process for monitoring compliance with EPSDT services requirements including periodicity schedule
Evidence of case management function providing education and counseling for patient compliance
Process for ensuring follow-up evaluation, referral and treatment in response to EPSDT screening results
Linkage agreements between MCO providers and behavioral health providers to assure provision of EPSDT services
Copies of practitioner training materials and other educational/informational materials and attendance records
Process for calculating EPSDT participation and screening rates including quality control measures
Evidence of submission of EPSDT Encounter Records, including special EPSDT procedure codes and referral codes

Reports

EPSDT CMS-416 report (MCO Report #93)
Quarterly reports of EPSDT activities, utilization and services (MCO Report #24)

File Review

Sample of UM and member and provider appeals related to EPSDT services selected by the EQRO

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.	Full-2013	Full	Includes review results for each subcontractor The MCO has subcontractor agreements with the following entities: Triad Prest and Associates NIA National Research Corp NRC MHNet McKesson Express Scripts ESI Chamberlin Edmonds Central KY Interpreter Avesis Vision Avesis Dental Akorbi Translations Advanced Medical Reviews Accipio Language All subcontractor agreements contain provisions for the reporting responsibilities of the subcontractor and for the revocation of the delegation.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Onsite, Coventry provided evidence of monitoring reports for its subcontractors as well as the Audit Results Letter that is sent to subcontractors after each audit.	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full-2014	Full	Includes review results for each subcontractor Onsite, evidence of pre-delegation audits was submitted for all subcontractors.	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Full-2014	Full	Includes review results for each subcontractor This requirement was addressed in the MCO's Oversight of Delegated Subcontractors Policy. The MCO submitted evidence of monitoring and oversight in the form of audit reports and Oversight Committee Meeting minutes for all subcontractors.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Full-2014	Full	Includes review results for each subcontractor This requirement is addressed in the Delegation Charter. The MCO's monitoring documentation identified an area of deficiency for	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			subcontractor McKesson in which a corrective action was taken. Onsite, it was confirmed that McKesson is the only subcontractor on a corrective action and evidence of the corrective action, it's monitoring and implementation was provided.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.	Full-2013	Full	Includes review results for each subcontractor This requirement is addressed in the MCO's subcontractor agreement whereby the MCO retains the right to approve, suspend, or terminate any provider selected by a subcontractor. This requirement is evidence in all of Coventry's subcontractor agreements.	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Full-2014	Full	This requirement is addressed in the MCO's subcontractor agreement.	
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the	Full-2013	Full	Includes review results for each subcontractor The provision that the subcontractor will indemnify and hold harmless the	

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.			Commonwealth and all members from liability arising in connection with the MCO's contract with the subcontractor is contained in the MCO's subcontractor agreements with each delegate.	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.	Full-2013	Full	Includes review results for each subcontractor This requirement is addressed in the MCO's subcontractor agreements.	
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such	Full-2013	Full	List subcontractors contracted with the MCO and type of services provided This requirement is addressed in the Delegation Oversight Responsibilities Policy. The MCO submitted subcontractor agreements for the following delegates: Triad: UM for chronic pain Prest and Associates: BH Chart reviews	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontractors within ten (10) days following termination.			NIA: High technology radiology National Research Corp: HRAs for members MHNet: BH network McKesson: Nurse hotline for members Express Scripts ESI: Retail pharmacy network Chamberlin Edmonds: identifies members who may qualify for SSI Central KY Interpreter: Translation services Avesis Vision: Vision provider network Avesis Dental: Dental provider network Akorbi Translations: Translation services Advanced Medical Reviews: Peer review services Accipio Language: Translation services	
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Full-2013	Full	Includes review results for each subcontractor	

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is included in all subcontractor agreements.	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
H. Contain a prohibition on assignment, or on any	Full-2013	Full	Includes review results for each	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
further subcontracting, without the prior written consent of the Department;			subcontractor This requirement is included in all subcontractor agreements.	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements.	
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,	Full-2013			
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,	Full-2013		Includes review results for each subcontractor	
(2) all QAPI requirements,	Full-2013		Includes review results for each subcontractor	
(3) all record keeping and reporting requirements,	Full-2013		Includes review results for each subcontractor	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(4) all obligations to maintain the confidentiality of information,	Full-2013		Includes review results for each subcontractor	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	Full-2013		Includes review results for each subcontractor	
(6) all indemnification and insurance requirements, and	Full-2013		Includes review results for each subcontractor	
(7) all obligations upon termination;	Full-2013		Includes review results for each subcontractor	
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;	Full-2013	Full	Includes review results for each subcontractor This requirement is included in all subcontractor agreements. The plan submitted evidence of annual monitoring for each subcontractor.	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Full-2014	Full	Includes review results for each subcontractor The MCO provided a copy of MHNet Specialty Service, LLC's NCQA Full Accreditation certification and survey report. Onsite it was confirmed that MHNet is	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the only NCQA accredited subcontractor.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Full-2013	Full	Includes review results for each subcontractor This requirement is addressed in the Oversight of Delegated Subcontractors Policy.	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Full-2013	Full	Includes review results for each subcontractor This requirement is addressed in all of the MCO's subcontractor agreements.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Full-2013	Full	Includes review results for each subcontractor This requirement is addressed in all of the MCO's subcontractor agreements.	
The requirements would be applicable to Subcontractors characterized as Risk Arrangements. The requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Members.	Full-2013	Full	This requirement is addressed in the Delegation Summary Report.	
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of	Minimal - Coventry submitted copies of their Subcontractor Monitoring reports for Q1 2014, Q2 2014, Q3 2014 and Q4 2014, which were submitted to KDMS to demonstrate disclosure of	Minimal	The MCO submitted copies of their subcontractor monitoring reports for all quarters of the 2015 review year to demonstrate its disclosure of	MCO did not provide a response.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.	subcontractors. Coventry did not submit a revised oversight policy containing the contract language that Coventry informs the Department of any subcontractor that provides services which engages another subcontractor in the performance of any term of the contract which in one year exceeds the lesser of 25k or 5% of the subcontractor's operating expense. **Recommendation for CoventryCares:** The Oversight Policy should be updated to address the regulatory language and disclosure of subcontractors to DMS. **DMS Response:** Since IPRO recommended that the policy be updated in the previous three compliance reviews, an LOC /CAP maybe issued. **MCO Response:** The Oversight Policy will be updated to address the regulatory language and disclosure of subcontractors to DMS		subcontractors to DMS. Missing from the Oversight Policy is language that the plan informs the department of any subcontractor which provides services for the plan and engages another subcontractor and that subcontractor earns 25k or more or 5% of the original subcontractor's operating budget. **Recommendation for CoventryCares** The Oversight Policy should be updated to address the regulatory language and disclosure of subcontractors to DMS	

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	25		1	
Total Points	75		1	

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.92**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
Suggested Evidence

Documents

List of subcontractors including type(s) of services provided and date of initial delegation
Contract with each subcontractor
Accreditation certificate and report for each subcontractor
Policies and procedures for subcontractor oversight
Subcontractor Oversight Committee description, meeting agendas and minutes
Documentation of ongoing oversight of subcontractors including follow-up
List of subcontractors terminated during the period of review
Evidence of DMS notification of all new subcontractors and terminated subcontractors
Evidence of disclosure of subcontractor activity to DMS

Reports

Pre-delegation evaluation report for new subcontractors
Periodic, formal evaluation reports for each subcontractor, including those with accreditation
Subcontractor certificate of accreditation and survey report

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Final Findings

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
1.0 Definitions				
Care Coordination means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.				
Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				
Children with Special Health Care Needs means Members who have or are at increased risk for chronic physical,				

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
35.2 Care Management System				
As part of the Care Management System, the Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.	Full-2013	Full	Addressed in policies and procedures CM-004 Complex Care Management, CM-005 Case Plan – Care Management, CM-017 Care Management for Persons with Special Needs and job descriptions for Care Management Associate, Complex Case Manager and Social Worker.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Demonstrated in sample CM files provided for review onsite.	
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.	Full-2013	Full	Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results) Addressed in policy and procedure CM-006 Referral Sources – Case Management. According to MCO Report #79 HRAs, In Q1 and Q2 2015, HRA completion rate ranged from 10-15% for non-pregnant members (within 90 days) and between 0-10% for pregnant members (within 30 days).	
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.	Full-2013	Full	Addressed in CM policies and procedures CM-004 Complex Care Management, CM-005 Case Plan – Case Management, CM-007 Case Management – High ED Utilization, CM-009 Clinical and Social Co-Management in Case Management, CM-011 Members in Foster Care and Adoption Assistance, CM-012 Case Management for Adult Guardianship, CM-017 Case Management for Persons with Special Needs, CM-020 Case Management for Homeless Members, among others.	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full-2014	Full	Addressed in 2015 HEDIS/HK/EPSDT/Foster Work Plan, policy and procedure CM-029	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Measuring Effectiveness of CCM, CM-010 Access to Special Needs Providers, CM-035 Continuity and Coordination of Care.	
35.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Full-2013	Full	Addressed in CM-005 Case Plan – Case Management Evidenced in CM files provided for review onsite.	
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Full-2013	Full	Addressed in CM-004 Complex Case Management and CM-005 Case Plan.	
The Contractor shall identify a Member with special physical and behavioral health care needs and shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent	Full-2013	Full	Identification of members with special physical and behavioral health care needs is addressed in CM-006 Referral Sources – Case Management and CM-024 Identification of BH Members – Case Management. Comprehensive Assessment for CM is addressed in policy and procedure CM-004 Complex Case Management.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
with the Primary Care Provider's clinical treatment plan and medical diagnosis.			Guidelines for referral to CM programs are addressed in policy and procedure CM-006 Referral Sources – Case Management and CM-004 Complex Case Management. An appropriate Care Plan including medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan is addressed in policy and procedure CM-005 Case Plan –CCM. Demonstrated in CM files provided for review onsite.	
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full-2013	Full	Includes review results for Care Coordination and Complex Case Management files Comprehensive Assessment for CM is addressed in policy and procedure CM-004 Complex Case Management. Care Coordination File Review Results 10 files were reviewed. 10 of 10 files contained a comprehensive assessment. Complex Care Management File Review	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Results 10 files were reviewed. 10 of 10 files contained a comprehensive assessment.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Full-2013	Full	Includes review results for Care Coordination and Complex Case Management files An appropriate Care Plan including medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan is addressed in policy and procedure CM-005 Case Plan –CCM. Care Coordination File Review Results 10 files were reviewed. 10 of 10 files contained an appropriate Care Plan. Complex Care Management File Review Results 10 files were reviewed. 10 of 10 files contained an appropriate Care Plan.	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on	Minimal - Addressed in Policy and Procedure CM-011 Case Management for Members in Foster Care and Members	Substantial	Care Coordination for DCBS clients is addressed in policy and procedure CM-011 Case Management for Members in Foster Care and Members Receiving Adoption	**MCO Response** The foster care team continues to follow and improve upon the care coordination for the DCBS clients addressed in policy and procedure

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Receiving Adoption Services outlines the procedures for identification and management for DCBS clients. It states that the MCO Liaison will coordinate the needs of foster and adoption assistance members whether they are enrolled in the CM program, including, the MCO Liaison participating in "service plan monthly meetings" with DCBS to address needs of the member; providing guardians with information on the WIC program and general health concerns; and referring guardians to available community resources. The Policy and Procedure states that Foster care members are considered ISHCN (as are adoption assistance members). Additionally, it states that the MCO liaison will work with the case manager for those who are enrolled in case management (CM) and that the Policy and Procedure for complex care management (CM-004) will be followed. Policy and Procedure CM-017		Services. During the interview, Coventry described monthly meetings with DCBS at which the needs of members in Foster care are discussed and addressed. Additionally, members are assessed using risk profiling and needs are addressed accordingly. Care coordination activities are described in MCO Report #20 Utilization of Subpopulations and ISHCN. Activities include resolving medication issues (prior authorizations, eligibility issues), service denials (incorrect terminations, TPL issues, incorrect demographic information), ID cards/Member ID #s (inquires from case workers, replacement cards); prior authorization (review of denials, assistance provided), contacts with foster family (for screenings, assistance with acute needs), and coordinating school-based services. Due to the very large number of DCBS clients enrolled in Coventry (~4,000-5,000), it is not possible to have a monthly case conference for each member. However, both DCBS and Coventry have found that the current process ensures the members' needs are addressed.	CM-011. Through the analytic process CoventryCares has identified multiple areas of need In the DCBS clients. Two of these areas of need are currently being addressed with specially trained personnel to help increase the efficiency of services offered. One area identified is Behavioral Health. This includes outreaching DCBS for members that go to an inpatient behavioral health facility, members that are being decertified and members that are preparing to discharge from a behavioral health facility. An example of this type of outreach included 550 members that were receiving antipsychotic medications. All of these members were outreached an assessed for needs. Case management contact information was also provided for any future needs. The Medical Health outreach includes the following areas: Medically Fragile, Commission for Children, hospital inpatient, and Core members. (Core members include high ER usage, high inpatient admissions, and top one percent at risk members.) Each month any new members in the above areas are outreached and assessed for case management needs. Along with outreach and assessment of specialty populations, the foster care team also

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Case Management of Persons with Special Needs notes that although DCBS and DAIL clients are considered ISHCN, there are separate Policies and Procedures for those individuals (CM-011 and CM-012, respectively). During the onsite interview, Coventry provided a PowerPoint presentation and discussed care coordination for DCBS clients. Details of the presentation included: as of March 2015, ~4,700 DCBS (Foster/Guardianship) clients were enrolled; during Q2 & Q3 2014, outreach included 2,364 contacts to 624 members. The majority of contacts were for foster care/adoption coordination purposes (1,594 of 2,364, 67%); a total of 732 assessments for 599 members were conducted for current and ongoing needs; a very small percentage was found to need acute or complex care management. Of 732 assessments, 53 (~7.2%) met criteria; of those, 43 opted-out		Coventry stated it would welcome and consider suggestions for other practical ways to manage these members. The 2015 QM Program Description addresses the DCBS/Foster population under II. Program, on page 2, describing the analysis, monitoring and evaluation of populations with special risk status and under V. Objectives, on page 8, item E, "to support objectives aimed at the development, monitoring, and servicing of members with complex and special needs..." The DCBS/Foster population is addressed in the 2015 QM Work Plan on page 19 (under Appendix N/HEDIS/EPSDT)as well as in the separate HEDIS/HK/EPSDT/Foster Work Plan 2015. Coventry has monitored the following indicators for the DCBS population: - Healthy Kentuckians Performance Measures for ISCHN Utilization and Access to Care: rates for the DCBS population often exceeded the rates for the overall population. For those that did not, the rates were ≥ 90% and less than 5 percentage points lower than the overall rates.	provides coordination of care activities for all of our foster care population. This includes nonclinical staff handling such items as the following: ID card request, providing member ID numbers, service plan receiving , sending signed service plans, and loading service plans into the Coventry system Coventry currently utilizes population analytics to manage the large number of foster children that DCBS has covered with Coventry. Coventry will continue to work to effectively manage this population. Coventry will continue to exam avenues that effectively manage special and high risk populations, including those with complex needs. Coventry will continue to monitor the Healthy Kentuckians Performance Measures and address any areas in which rates decrease. If any measures decrease from the established baseline then outreach attempts will be made to those foster care members.

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and 10 were enrolled in CM. The presentation did not specifically detail the care coordination activities, i.e., referral/linkage to community resources, coordination with DCBS, foster parents, providers, BH authorizations. Regarding outreach to DCBS clients, data on the number/percentage of the total DCBS member population had outreach attempts, were contacted, and the outcome of the contacts would be informative. Coventry did provide a document, Foster Care Listing, for Q3 2014, which listed members and outreach efforts. The majority of the members were listed as "No HRA/No CM Outreach" and with a result of "Max Attempts". Coventry differentiated case management as for an acute need. Regarding coordination, the presentation indicated that case management staff handles assessment, outreach, care		- Grievance and Complaints – Coventry indicated that any/all grievances and complaints by DCBS clients are routed to the MCO's DCBS Liaison. The G/A Manager works with the DCBS Liaison to investigate and resolve the complaint. - Newborn Abstinence Syndrome (NAS) – Coventry described its program for NAS. The newborns and their mothers are followed for 1 year minimum. Coventry described barriers to conducting a satisfaction survey specific to the DCBS members. Since the MCO cannot directly contact the member/foster family without DCBS' permission and because of the frequent change in foster family/address, a survey would need to be sent to the guardian, which is the State/case worker, not the member; therefore, this is not feasible. **<u>Recommendation for Coventry</u>** Coventry should continue to work with DMS and DCBS to find the best strategies to monitor and manage the needs of the large DCBS population.	Coventry has streamlined the complaint and grievance procedure to go to one Coventry employee for one on one assistance and handling. This process will continue in order to have the best possible outcome. Coventry will continue to outreach the Mothers that have a Substance Use Disorder (SUD). Every attempt will be made to engage the SUD mothers and their infants in case management. When the member agrees to enroll in case management the member will be followed for a minimum of one year. Coventry offers several incentives for this population of members, thus encouraging the members to stay engaged in case management. In 2016 Coventry introduced a new charting system that requires a health risk assessment to be completed upon the initial outreach. This is being used as a tool to further outreach and assess DCBS satisfaction with Coventry members. Coventry will continue to pursue an effective and beneficial relationship with DMS and DCBS. Coventry will proceed to meet monthly with DMS and DCBS to explore any new avenues to

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	coordination and referrals to community resources; Mental Health (MH) CM staff coordinates authorizations for inpatient and outpatient Behavioral Health (BH) care. The MCO stated that the CM program is transitioning to where MH case managers perform CM functions, rather than just UR functions. The MCO stated that cross-training between MH and physical health (PH) CM was occurring. None of the Policies and Procedures addressed tracking and analyzing indicators for the DCBS population. UM-017 Monitoring of Over and Under Utilization, describes how the MCO will collect, review, analyze and report on utilization data to assess performance; however, this is a general policy, and not specific to the DCBS population. The QI Program Description (QIPD), page 5, Objectives, notes that additional special emphasis is placed on disabled, women, infants, children, adolescents,		**Final Review Determination** No change in review determination. **Recommendation for DMS** DMS should review the contract requirements for DCBS clients, specifically, the requirement for monthly meetings, and clarify if this refers to general meetings with DCBS or member-specific meetings with DCBS.	monitor and manage the needs of the DCBS population. This relationship will prove to be effective by continuing to use the established analytics. This will not only benefit the corporate partners but also the Coventry members that are served.

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	young adults, and EPSDT; however, this does not specifically address the required metrics for the DCBS population as required by the Contract. The HEDIS EPSDT Work Plan did not contain any specific references to measurements or interventions specific to the foster population. Report #96 Audited HEDIS Reports provides HEDIS measures stratified by category of aid, gender and race; however, no comparisons or analysis are presented. The report also includes the Healthy Kentuckians (HK) measures. These rates are not stratified. The MCO reported the set of measures for ISHCN, but no comparisons or analysis were provided. The MCO provided Report#29 Grievances and Appeals for Q4 2014. This report had a general focus and did not specifically focus on DCBS clients.			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Coventry provided copies of 3 monthly corrective action plan (CAP) reports to DMS (utilization for children in foster care: well visits, hearing screens, immunizations, lead testing). Data for other months was not provided. The report contains comparisons between the ISCHN and rest of member populations for the following metrics: well visits, hearing tests, vaccinations, and lead testing. However, the specifications used to calculate the measures and the specific member age group(s) included were not clear. The MCO was asked for clarification but was not able to provide it as the staff member who calculated the measures was not available. Coventry was to submit the following follow-up documents in response to the onsite review: data from grievances, UM and concerns for the DCBS population with evidence of aggregation and analysis and results for the satisfaction survey for children in foster care. A copy of a			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	satisfaction survey form for complex care management was provided, but it did not relate to the foster care population. **Recommendation for CoventryCares:** Coventry should include a specific objective in the QIPD related to tracking, analyzing, reporting, and when indicated, developing and implementing corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population. Coventry should include a task in the QI Work Plan for the above-mentioned objective. Coventry should stratify both HEDIS and HK measures across the member populations, compare the rates across the populations, analyze the information and develop and implement corrective actions when warranted. Coventry should do the same for			

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	measures related to utilization (e.g., Emergency Department (ED), inpatient, specialty care), complaints and grievances, and services specific to the DCBS population. Regarding outreach to DCBS clients, Coventry should track the number/percentage of the total DCBS member population that had outreach attempts, were contacted, and the outcome of the contacts. Coventry was to submit the following follow-up documents in response to the onsite review: data from grievances, UM and concerns for the DCBS population with evidence of aggregation and analysis and results for the satisfaction survey for children in foster care. A copy of a satisfaction survey form for complex care management was provided, but it did not relate to the foster care population. **DMS Response:** This element received Non-Compliance in 2013			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and 2014 and a Minimal in 2015. All three years required a Corrective Action Plan. DMS has concerns. **MCO Response:** (CM-017 was attached by MCO but removed by IPRO) The presentation is not an official document and was not considered all-inclusive. Our policy is all-inclusive .This Policy CM-017 addresses this. DCBS does not provide direct contact information for foster children. MCO relies on the DCBS regional worker or case worker to let the MCO know if member wants or needs CM. If CM is indicated through claims identification. The DCBS Regional worker reaches out to the foster parent. CM will collaborate with UM to update policy UM-017 in order to add specific language for foster care and ISHCN's. Vicki Meska said that the bed days report is			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	part of what IPRO is seeking. The policy should also specifically include the DCBS/DAIL population. MCO sends a report monthly and quarterly to all regional MCO liaisons and DCBS management detailing the number of service plan reviews conducted for guardianship, foster and adoption assistance member outcome decisions, such as referral to case management and rationale for decisions. This report also includes claims, but it is not considered a report on utilization. CM is not responsible for the HEDIS EPSDT workplan. The 411 report and EPSDT is a standard report for all MCOs and no data specific to foster care is required. DCBS must provide the contact information for the DCBS population and all surveys will be mailed to foster care members participating in CM.			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	CM/UM/QI/BH/PR/G&A: need to develop a work group on how to provide IPRO with a report specific to the DCBS population. This report to include bed days, access, complaints and grievances. This report should be completed as part of the corrective action plan. This is not a standard report that we are required by contract to submit. A documented process should be developed so that this report becomes standard report/documentation for all IPRO audits. CM will need to develop a report specific for IPRO even though this is not a standard report required by the contract. **Final Review Determination:** No change in review determination. Regarding the contract requirement: "The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	clients" and the MCO's responses: Coventry's Policy and Procedure CM-011 indicates that the MCO Liaison will coordinate the needs of foster and adoption assistance members whether they are enrolled in the CM program, by: - Participating in "service plan monthly meetings" with DCBS. - Providing guardians with information on the WIC program and general health concerns and referring to available community resources. It was understood that the case management presentation did not encompass all information on CM for DCBS clients; however, it was the most detailed information available for review related to care coordination activities for DCBS members. The document was considered "official" in that it was provided for purposes of the compliance review.			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Policy and Procedure CM-017 states that although DCBS and DAIL clients are considered ISHCN, there are separate Policies and Procedures for those individuals (reference CM-011 and CM-012, respectively). The MCO is responsible for ongoing monitoring and care coordination of all enrolled members, especially those who are DCBS clients, regardless of whether the member's needs are managed primarily by DCBS and/or if there is no need for MCO case management. Additionally, all enrollees that are new to MCO should have a Health Risk Assessment conducted, including DCBS clients. Regarding the Contract requirement: "The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access,			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	complaints and grievances, and services specific to the DCBS population" and the MCO's responses: The activity described above, specific to the DCBS population, is, in fact, a contract requirement, though it is not specifically listed as a regular "report" in the contract Appendix. For the DCBS population, Coventry needs to measure, report, analyze, and develop and implement improvement strategies on indicators of utilization, access, complaints and grievances, and services that are specific to the DCBS population. Examples of possible metrics to use include, HEDIS and EPSDT/(CMS-416). Coventry can choose the specific measures, as long as each of the required categories is addressed. This is the MCO's contractual responsibility, regardless of which department fulfills the requirement.			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	To demonstrate compliance with this requirement, Coventry indicated that results for a satisfaction survey for children in foster care would be provided. The MCO provided a copy of a complex care management satisfaction survey. If the MCO chooses to use this satisfaction survey to meet the requirement, the MCO should use the contact information in the CM file or obtain it from DCBS, if needed, so that satisfaction with CM can be reported for the DCBS population that is enrolled in CM. Coventry should make its existing report, "Foster Care Listing (Q3 2014)" more useful by including the number/percentage of the total DCBS member population that had outreach attempts, were contacted, and the outcome of the contacts. However, this is not a contract requirement.			
Members, Member representatives and providers shall be provided information relating to care management	Full - 2013	Full	Addressed in the Member Handbook, Section 5 Covered Services and Limits, Case	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services, including case management, and information on how to request and obtain these services.			Management and Disease Management (page 35). Addressed in the Provider Manual, Section 3, C. Care Management and Other Support Available (page 39) and Section 5, I Medical Care Management.	
36.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.	Full-2013	Full	Addressed in policy and procedure CM-006 Referral Sources – Case Management, CM-011 Case Management for Members in Foster Care and Receiving Adoption Services, CM-012 Case Management for Adult Guardianship, CM-024 Identification of Behavioral Health Members – Case Management, CM-031 Population Assessment. Addressed in CORE (**Consolidated Outreach and Risk Evaluation)** Aetna	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Medicaid's methodology for identifying high risk members for outreach and evaluation. CORE is based on three risk metrics: General Risk: general score to identify high risk members – where the top 1% of members, ranked by highest score, is considered "high risk." ED Risk: logistic regression model that assesses the likelihood of a member utilizing the ED in the next 12 mos. – where members having a probability of 80%+ are considered high risk for an ED visit. IP Risk: logistic regression model that assess the likelihood of a member utilizing the IP in the next 12 mos. – where members having a probability of 50%+ are considered medium (50-69%) or high risk (70%+) for an IP admit. IP admit risk assessment excludes maternity admits. Demonstrated in CORE-4 reports, MCO Report #20 Utilization of Subpopulations and ISHCN Monthly DCBS Meeting minutes	
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Full-2013	Full	Addressed in policy and procedure CM-006 Referral Sources – Case Management, CM-011 Case Management for Members in Foster Care and Receiving Adoption Services, CM-012 Case Management for Adult Guardianship, CM-024 Identification	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			of Behavioral Health Members – Case Management, CM-031 Population Assessment. Addressed in CORE (**Consolidated Outreach and Risk Evaluation)** Aetna Medicaid's methodology for identifying high risk members for outreach and evaluation. Demonstrated in CORE-4 reports, MCO Report #20 Utilization of Subpopulations and ISHCN Monthly DCBS Meeting minutes	
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-2013	Full	Addressed in policy and procedure CM-004 Complex Case Management. Demonstrated in case files provided for review onsite.	
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT Special Services.	Full-2013	Full	Includes review of MCO Report #20 Utilization of Subpopulations and ISHCN (see Quarterly Desk Audit results) Addressed in policy and procedure CM-006 Referral Sources – Case Management, CM-011 Case Management for Members in Foster Care and Receiving Adoption Services, CM-012 Case Management for Adult Guardianship, MC-017 Case Management of Persons with Special	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Needs, CM-020 Case Management for Homeless Members, CM-024 Identification of Behavioral Health Members – Case Management, CM-031 Population Assessment. Addressed in CORE (**Consolidated Outreach and Risk Evaluation)** Aetna Medicaid's methodology for identifying high risk members for outreach and evaluation. Demonstrated in quarterly MCO Report #20 Utilization of Subpopulations and ISHCN that describes identification and outreach related to CCSHCN, Foster/Adoption Assistance clients, homeless members, Guardianship clients, and special programs, such as, Smoking Cessation, Transitional Care, Disease Management, ED Utilization, and Lock-In.	
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Full-2013	Full	Addressed in CM-004 Complex Case Management and CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Service**.** Demonstrated in case notes provided with pre-onsite materials and MCO Report #20 Utilization for Subpopulations and ISHCN.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2013	Full	Addressed in policy and procedure CM-006 Referral Sources – Case Management, CM-011 Case Management for Members in Foster Care and Receiving Adoption Services, CM-012 Case Management for Adult Guardianship, CM-024 Identification of Behavioral Health Members – Case Management, CM-031 Population Assessment. Addressed in CORE (**Consolidated Outreach and Risk Evaluation)** Aetna Medicaid's methodology for identifying high risk members for outreach and evaluation. Demonstrated in CORE-4 reports, MCO Report #20 Utilization of Subpopulations and ISHCN Monthly DCBS Meeting minutes	
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	Full-2013	Full	Addressed in policy and procedure CM-005 Case Plan –Case Management. Demonstrated in case files provided for review onsite.	
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.	Full-2013	Full	Addressed in policy and procedure CM-004 Complex Case Management, CM-010 Access to Special Needs Providers, CM-017 Case Management for Persons with Special Needs, CM-029 Measuring the	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Effectiveness of CCM, Demonstrated in the report Performance Measurement and the Effectiveness of Disease Management and Adherence to Clinical Practice Guidelines.	
36.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.	Minimal - Addressed in Policies and Procedures CM-017 Case Management of Persons with Special Needs and CM-102 Case Management for Adult Guardianship address the requirements with the exception that neither document specifically states that addresses that the contractor shall be responsible for the ongoing care coordination for DCBS and Adult Guardianship clients whether or not enrolled in case management. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u>	Substantial	Includes review results for DCBS Service Plans and DCBS Claims/Case Management files; however, DCBS Service Plans were not reviewed for 2016. Addressed in CM-017 Case Management of Persons with Special Needs, CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services and CM-012 Case Management for Adult Guardianship <u>Service Plans</u> Efforts to obtain Service Plans are evidenced in the DAIL meeting minutes, DCBS meeting minutes, Service Plans Tracking Document and emails submitted by Coventry. <u>Care Coordination</u> Care Coordination for DCBS and DAIL clients is addressed in policy and procedure	The DCBS regional liaisons are sent a list monthly of the members that are in foster care. This list includes which members are in need of a service plan. When service plans are received from DCBS, the service plan, is reviewed, signed, entered into the computer system and a signed copy is then sent back to the liaison. Coventry will continue to request service plans monthly via email and at the DAIL monthly state meetings. The efforts will continue to be documented and recorded in the DAIL monthly list. Coventry will continue to record and document the care coordination that is provided to the members. The new charting system that began in 2016 will make outreach attempts tracked

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	5 of 12 files in the sample were provided (10 + 2 oversample). 0 of 3 demonstrated ongoing care coordination; however, 2 were in long term placements. 3 of 5 were referred to CM, 2 were unable to determine. 0 of 3 referred were enrolled in CM. Therefore, 5 of 5 were not applicable for coordination with DCBS for developing and changing the care plan. 0 of 5 demonstrated monthly meetings with DCBS. <u>DCBS Claims/Case Management files</u> For the 3 child members, 0 of 3 had documentation of well visits or EPSDT Services. 0 of 3 had documentation of outreach for EPSDT services Since the file results may be difficult to interpret, a summary of each of the cases is below Case #1 – An adolescent resident in residential placement. Attempts to reach DCBS worker were not successful. The member		CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services and CM-012 Case Management for Adult Guardianship. Demonstrated in monthly DCBS and DAIL meeting minutes at which the needs of members are discussed and addressed. Additionally, members are assessed using risk profiling and needs are addressed accordingly. During the interview, Coventry noted that there is a dedicated CM team assigned to manage DCBS and DAIL clients. The team is comprised of 3 RNs and 1 non-clinical staff member. The MCO also described the following strategies to monitor and coordinate care for DCBS members: CORE predictive modeling, tracking members with inpatient BH decertification/discharge, and tracking by a dedicated social worker CM, receipt of lists of medically fragile members, lists from inpatient hospitals. Coventry also demonstrated a look-up tool created specifically for this population. The tool allows DCBS caseworkers to access a member's medical history, providers, medications and other pertinent	and recorded more efficiently. Coventry will continue to use the risk profiling and these identified members will be discussed during the monthly meetings. The member's that are discussed will be documented in the monthly meeting minutes and in the member's individual record. Coventry's dedicated DCBS and DAIL CM team will continue to use the established analytic processes to outreach the members that are in higher risk categories. The categories include the following: Outreaching DCBS for members that go to an inpatient behavioral health facility, members that are being decertified and members that are preparing to discharge from a behavioral health facility, Medically Fragile, Commission for Children, hospital inpatient, Core members (Core members include high ER usage, high inpatient admissions, top one percent at risk) for both the foster care children and DAIL are outreached. The DAIL members that are receiving ACT services are outreached and assessed for case management needs. Coventry will continue to provide the DCBS case workers with a look up tool. This tool allows DCBS workers to access each foster care

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	was screened but found not appropriate for CM due to BH condition and residential placement. There was no evidence that the member was followed or status updated (attempted or done). At a minimum, an annual update would be expected. No EPSDT services or outreach documented. Case #2 – Child/toddler-aged member termed during Q1 2015. Note dated in 2014 states "Email sent/received" with no further detail. No EPSDT services or outreach documented. Case #3 Adult guardianship client. The member was placed in a long term facility. No attempts to contact DAIL/guardian and no meetings were documented. EPSDT not applicable – adult. Case #4 – Child/school-aged member termed 12/31/14. The member was referred for ECM, but did not meet criteria. A note dated in 2014 states "Email		information. Care coordination activities are also described in MCO Report #20 Utilization of Subpopulations and ISHCN. Activities for DCBS members include resolving medication issues (prior authorizations, eligibility issues), service denials (incorrect terminations, TPL issues, incorrect demographic information), ID cards/Member ID #s (inquiries from case workers, replacement cards); prior authorization (review of denials, assistance provided), contacts with foster family (for screenings, assistance with acute needs), and coordinating school-based services. Activities for DAIL members included discussion of members in long term placements, member-specific issues, follow-up requests for CM services, coordination with State workers to meet members' needs, managing member address corrections, and how to manage member incarcerations. Due to the very large number of DCBS clients enrolled in Coventry (~4,000-5,000), it is not possible to have a monthly case conference for each member. However, both DCBS and Coventry have found that the current process ensures the members'	member's medical history, previous providers, medications and any other pertinent information. Coventry will continue to provide the following activities for the foster care members: resolving medication issues, prior authorizations, incorrect terminations, service denials, eligibility issues, ID cards/Member ID #s (inquiries from case workers, replacement cards); contacts with foster family (for screenings, assistance with acute needs), and coordinating school-based services. Coventry's specialized DAIL case managers will continue to provide the following activities to the DAIL members: managing member address corrections, co-managing member incarcerations, assisting with coordinating ACT services, member-specific issues, following up with member specific issues, and participating with any needs related to long term placements. The previously stated strategies will continue to be used in order to outreach the large number of DCBS members that Coventry has.

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	sent/received" with no further detail. No meetings with DCBS were documented. No EPSDT services or outreach documented. Case #5 – Adult guardianship client. A 2012 communication with the member's guardian in 2012 indicates "no CM needs. The member is living in a Personal Care Home (PCH), will contact if needed." Referred to CM but not enrolled. No meetings with DAIL were documented, would expect an annual status update at a minimum. EPSDT services not applicable – adult. During the onsite interview, the MCO indicated that some of the regional liaisons were difficult to reach and that many had changed recently so it was hoped more successful contact could be made. **Recommendation for CoventryCares:** Coventry should address the Contract language in		needs are addressed. Coventry stated it would welcome and consider suggestions for other practical ways to manage these members. Monthly List of Foster Care members and DAIL to DMS evidenced in emails submitted by Coventry. <u>DCBS Service Plan File Review Results</u> 10 files in the sample were provided 0 of 10 were referred to case management, as the members did not require CM referral. 0 of 10 had evidence of ongoing care coordination <u>DCBS Claims/Case Management</u> 10 files were reviewed 10 of 10 files contained evidence of a PCP visit 10 of 10 files contained evidence of EPSDT services **<u>Recommendation for Coventry</u>** Coventry should continue to work with DMS, DCBS, and DAIL to identify the most effective strategies to manage the large population of DCBS and DAIL clients enrolled in the plan.	Coventry will continue to work closely with DCBS and explore any newly identified categories of members. Coventry will continue to provide DCBS and DAIL with monthly list. Coventry will continue to record the email documentation of the monthly list that are provided. Coventry will continue to make every effort possible to provide coordination of care and intensive case management to all applicable DCBS and DAIL Coventry members. Coventry will continue to pursue an effective and beneficial relationship with DMS, DCBS and DAIL. This relationship will prove to be effective for not only the corporate partners but also the Coventry members that are served.

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	its Policies and Procedures "the Contractor shall be responsible for the ongoing care coordination clients, whether or not enrolled in case management". Coventry should develop and implement a process for ongoing care coordination for all DCBS/DAIL clients, regardless of enrollment in CM. Coventry should ensure that the required reports of DCBS/DAIL clients are submitted for each month. Coventry should ensure that discussion of all DCBS/DAIL clients is documented in monthly meetings with DCBS, regardless of enrollment in CM or not. Coventry should ensure that status updates are performed at regular intervals (annually at a minimum) for DCBS/DAIL clients in long term residential placements. Coventry should ensure that all		**Final Review Determination** No change in review determination.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	DCBS clients are monitored for receipt of well care and EPSDT services and if gaps are identified, outreach and other actions to promote the receipt of missing services are conducted. **DMS Response:** In 2013 and 2015 this element received a Minimal and in 2014 a substantial. DMS has concerns CM-017 submitted for P&P review of revisions. Updating the other policy as well. This is because the MCO created a report specifically for the DCBS meetings held monthly. The report was created with input from DCBS. It was not available during the months IPRO reports it missing. Service plans are reported to the state monthly and quarterly. Often times the services plans are incomplete and a determination for CM cannot be made because there is not enough information. MCO is			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	unable to receive all services plans even though repeated attempts are made and this is discussed at every monthly meeting with DCBS. Service plan information is gathered by the state. Coordination of care, supportive services and case management services are dependent on the communication from the field workers. MCO outreach attempts should be accepted as compliant. MCO should not be held accountable for non-responsiveness of the DCBS field worker. Contact information for the foster parents is essential to completing health risk assessments. Current contractual requirements specifically state duplication of services is prohibited. Members in residential placement or long-term care do not receive case management services because they are already receiving care and services from the facility. Upon discharge the CM discharge planner is notified and at that			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	time the member is provided outreach, coordination of care and case management services if indicated. Service plans already addressed. MCO's do not sign service plans as these are proprietary to the state. DAIL members have no contact information, as it is not provided by the state. No case management services for long-term care members if in greater than 30 days. Meeting dates were submitted. Already addressed services plans. Will elaborate on emails sent/received with further detail. Staff training. The policy was updated to include this information. Ongoing care coordination is provided regardless of enrollment in the CM program. CM-011 is compliant			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Minutes will capture member names moving forward. The DCBS workers have always had a placement for the child and follow up outpatient therapy or residential placement. MCO asks DCBS worker if the member is in foster care if the foster parents need support, because the DCBS worker has to agree to that and contact the foster parents first. More often than not, the DCBS worker does not return 3 attempts with verifiable VM's. A follow up letter is sent with contact info. MCO already performs care coordination for foster members whether or not they are enrolled as referenced in CM-011. CM policy CM-017 will be updated to say care coordination will be performed on members enrolled or not enrolled in CM. Contract Section 37.1 states; a quarterly report be submitted detailing the number of service plans.			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	All minutes from the DCBS meetings were provided. Members enrolled and not enrolled in CM are discussed at monthly meetings with DCBS. Policy CM-017 will be updated to state members enrolled or not enrolled in CM will be discussed at monthly DCBS meetings. CM-011 DOES state coordination of care is done regardless of CM enrollment status. See highlighted area on policy. CM - 011 Members in Foster Care and Adop **Final Review Determination:** No change in review determination. The review determination is based on the file review results related to documentation of care coordination, monthly meetings with DCBS and receipt of and follow-up for well care visits and EPSDT services for DCBS/DAIL clients, where applicable.			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Although DMS has indicated that review of Service Plans and signatures on Service Plans is not applicable for review, according to DMS, the MCOs remain responsible for coordination of care for DCBS members whether or not enrolled in the MCO's care management program and despite that DCBS is the primary care manager. Additionally, the MCOs remain responsible for ongoing coordination and monthly meetings for all DCBS members. Regarding the MCO responses to the File Review results: Coordination of care and supportive services remain the MCO's responsibility and, at a minimum, full and clear documentation for each member of attempts to outreach and coordinate with DCBS is expected for all DCBS members. If contact is unsuccessful, there should be documentation of efforts for all members via the monthly meetings.			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	While CMS-416/EPSDT reporting is not a CM activity, the MCO is responsible for ensuring that its DCBS members receive routine PCP visits and EPSDT services and should monitor and track this and make outreach attempts when necessary, as is required by the contract. Per discussion with DMS, provision of care coordination for DCBS and DAIL clients enrolled in the MCO is not considered a duplication of services. If a member's care is being managed by DCBS/DAIL, a facility or another agency, the MCO remains responsible. Per the contract, "The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services." Regarding members in long term care for greater than 30 days,			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	DMS indicated that the MCO remains responsible for following the status of these members. Regarding DAIL members, specifically: Per DMS, DAIL members' contact information is available, and in fact, Coventry currently submits a DAIL report to DMS that includes this information. Note that Policy CM-012 indicates that the DAIL member will be outreached and assessed by the MCO CM once the contact information is obtained. Regarding DCBS meeting minutes, these were not found in the MCO's document submissions. Regarding the Policies and Procedures, CM-017 and CM-012 were noted as not containing the contract language regarding ongoing care coordination. CM-011 was noted as compliant in the prior element. Additionally, the MCO needs to			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	ensure both that the Policies are complaint with the contract language and compliance with ongoing care coordination is demonstrated via member-specific documentation.			
36.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	Full-2014			
36.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.	Minimal - Addressed in Policy and Procedure CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services and CM-017 Case Management of Persons with Special Needs. Coventry provided descriptions of the DCBS meetings held between January and May 2014. The notes, minutes, or logs were	Full	Includes review results for DCBS Service Plans files, but review of DCBS Service Plans was not required for 2016. During the onsite interview, Coventry noted that efforts continue to obtain Service Plans for DCBS and DAIL clients. Monthly emails are sent to the DCBS regions and monthly meetings are held. Coventry also noted that there is no spot for the MCO signature on the Service Plan	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	not provided. Therefore, it cannot be determined which specific members were discussed at each of the meetings, regarding Service Plans and/or other issues. Since there are a total of 4,000+ DCBS clients enrolled and MCO reports indicate that ~2702 do not have Service Plans; it is not clear how each member could have been addressed in those 5 meetings. Coventry did provide a document, Foster Care Listing, for Q3 2014, which listed members and outreach efforts. The majority of the members were listed as "No HRA/No CM Outreach" and with a result of "Max Attempts". Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 5 of 12 (10 +2 oversample) requested files were provided. 0 of 3 demonstrated ongoing		form and that a new form was being used. Also, at times, the forms are incomplete and/or incorrect and efforts are made to obtain full and accurate information. Evidence of efforts to obtain Service Plans included emails to DCBS and DAIL, Service Plan tracking document.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	care coordination; however, 2 were in long term placements. 3 of 5 were referred to CM, 2 were unable to determine. 0 of 3 referred were enrolled in CM. Therefore, 5 of 5 were not applicable for coordination with DCBS for developing and changing the care plan. 0 of 5 demonstrated monthly meetings with DCBS. See element 35.2 above for further detail. **Recommendation for CoventryCares:** See above element 35.2 **DMS Response:** In 2014 this element received a substantial and in 2013 and 2015 has received a minimal and DMS does have concerns. **MCO Response:** Members are addressed on the monthly list, but they are not individually discussed unless there are issues requiring intervention. DCBS told us that we are the only MCO who			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	provides them with such detailed information and they are pleased with our performance. HRA's were addressed above. Service plans were addressed above. **Final Review Determination:** No change in review determination. The review determination is based on the file review results for documentation of monthly meetings with DCBS for the specific members. No minutes for the DCBS monthly meetings were found in the MCO's document submissions.			
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.	Not Applicable - Addressed in P/P CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 5 of 12 (10 +2 oversample) requested files were provided. **DMS Response:** In 2014 this element received a substantial and in 2013 and 2015 has received a minimal and DMS does have concerns.			.
33. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Full-2013			
33.8 Pediatric Interface				
School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the				

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department through fee-for-service Medicaid.				
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.	Full-2014	Full	Addressed in policy and procedure CM-017 Case Management for Persons with Special Needs. Evidenced in monthly DCBS meeting minutes, discussion of school-based services.	
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.	Non-Compliance - No Policy and Procedure for Pediatric Interface Services was found. No document addressing hospice/palliative services was found. The Member Handbook addresses hospice services as a covered service on page 32. This was the only reference to hospice and/or palliative services that was found.	Non-Compliance	No documentation was found to address provision of both curative care and palliative care/hospice services for pediatric members. In the Member Handbook, hospice care is addressed on pages 30 and 32 relative to co-pays and on page 34 relative to member liability for payment. During the interview, Coventry indicated that the MCO would pay for hospice care while FFS/waiver would be paid for other	**CM policy KY 7000.43 revised to include the case management actions relative to pediatric members receiving hospice care and concurrent curative and palliative care.** **Operations is reviewing the history of pediatric members who meet this criteria.**

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	During the onsite interview, documents to address this were requested. The MCO did not provide any follow-up documents. **Recommendation for CoventryCares:** Coventry should develop a new Policy and Procedure or revise an existing Policy and Procedure to address this requirement. **MCO Response:** This references a contract that was not in effect during the audit period. Pediatric interface is utilization management/prior authorization of services. Pediatric interface is not a case management function. **Final Review Determination:** No change in review determination. Per discussion with DMS, the ACA Pediatric Interface requirement for pediatric concurrent care, palliative hospice services, curative services and medications was a Contract requirement		services. Coventry also noted that this might be addressed in the policy and procedure for Covered Services and/or Member Liability. **Final Review Determination** No change in review determination.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	during the period of review. Additionally, regardless of whether Pediatric interface is a case management function, this is the MCO's contractual responsibility, and compliance is required.			
38.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.	Full-2013	Full	Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results) Coventry has submitted MCO Report #65 Foster Care and MCO Report #66 Guardianship each quarter, as required.	

Final Findings

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	21	2	0	1
Total Points	63	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.79**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Case Management/Care Coordination

Suggested Evidence

Documents

Policies/Procedures for:

- Identification of members for care management services
- Care coordination
- Comprehensive Assessment including guidelines for referral to care management programs
- Care Plan including criteria for care plan development
- ISHCN including identification, screening and assessment
- DCBS and DAIL clients
- Coordination of care for children receiving school-based services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and services for DCBS population.

Case manager and care coordinator position descriptions
Evidence of dissemination of information to members, member representatives and providers relating to care management services
Evidence of monitoring effectiveness of case management
Evidence of tracking, analysis, reporting and interventions for indicators measuring utilization, access, complaints and grievances, and services for DCBS population
Evidence of dissemination of information and materials specific to the needs of the ISHCN member
Evidence of practice guidelines or other criteria considering the needs of ISHCN

Reports

Reports of service plan reviews conducted for DCBS and DAIL clients (MCO Reports #65 and 66)
HRAs (MCO Report #79)
Utilization of Subpopulations and ISHCN (MCO Report #20)

File Review

Care Coordination and Complex Case Management files for a random sample of cases selected by EQRO
DCBS Service Plans and DCBS Claims/Case Management files for a random sample of cases selected by EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.7 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities.	
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Substantial - Member rights and responsibilities are communicated to members in the Member Handbook, Section 2 Rights and Responsibilities, pages 9 – 11; to network providers in the Provider Manual, Section 4 Member Services and Benefits, pages 42-43; and via the website, which is publicly available. Out-of-network providers may access the information on the website and Coventry stated that the information is provided to those providers on request. However, the MCO does not currently have a policy/procedure that addresses how member rights and responsibilities are shared with network providers, members and specifically, out of network providers. Upon discussion onsite, it was agreed that in order to resolve this requirement, Coventry could add	Full	Upon discussion onsite, CoventryCares provided Policy A-KY 4500.35 Member Rights and Responsibilities (revised 11/2015) which states how member rights are communicated to members and providers: Member rights and responsibilities are published in the Aetna Better Health® of Kentucky Member Handbook, which is distributed to all members upon enrollment and annually thereafter. Member rights and responsibilities are published in the Aetna Better Health® of Kentucky Provider Manual which is given to new practitioners upon joining the network and to participating practitioners annually. Out-of-network providers are informed via Aetna's website.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the following to its policy/procedure RR-002 Member Rights and Responsibilities: - Members are informed via the Member Handbook. - Network providers are informed via the Provider Manual. - Out-of-network providers are informed via the website and upon request. - This information is communicated publicly via the website. **Recommendation for CoventryCares:** Coventry should revise policy as agreed. **DMS Response:** Since IPRO recommended that the policy be updated in the previous year also, an LOC /CAP maybe issued. **MCO Response:** Coventry will add the following to its policy/procedure RR-002 Member Rights and Responsibilities: - Members are informed via the Member Handbook. - Network providers are informed via the Provider Manual. - Out-of-network providers are			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	informed via the website and upon request. - This information is communicated publicly via the website.			
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, first three bullets.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, fourth bullet.	
C. Consent for or refusal of treatment and active participation in decision choices;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, eighth bullet.	
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, sixth bullet.	
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2, first bullet from the top.	
F. Timely access to care that does not have any communication or physical access barriers;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2, second bullet from the top.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2,	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			fourth bullet from the top.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, eleventh bullet.	
I. Timely referral and access to medically indicated specialty care; and	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2, second bullet from the top.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 1, third bullet from the top.	
K. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network.	New Requirement	Non-Compliance	Upon discussion onsite, CoventryCares indicated that this language would be stated in an Aetna Policy effective 2/1/2016. The name of this policy was not specified.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 3 under Member Responsibilities, second bullet.	
B. Abide by the Contractor's and Department's policies and procedures;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2 under Member Responsibilities, tenth bullet.	
C. Become informed about service and treatment options;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2 under Member Responsibilities, twelfth bullet.	
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			under Member Responsibilities, third bullet.	
E. Report suspected Fraud and Abuse; and	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page two under Member Responsibilities, forth bullet.	
F. Keep appointments or call to cancel.	Full-2013	Full	This requirement is addressed in Policy RR-002 Member Rights and Responsibilities on page 2 under Member Responsibilities, eighth and ninth bullets.	
23.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 1, first paragraph.	
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 1, first paragraph.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full-2013	Substantial	This requirement is addressed in Policy MC-004 Member Handbook on page 1, first paragraph. Although CoventryCares provided an updated 2015 Member Handbook prior to onsite review, their website has the 2013-2014 Member Handbook posted. **Recommendation to CoventryCares of Kentucky**	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			It is recommended that Coventry update their website to reflect the current Member Handbook.	
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 1, first paragraph.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 1, under procedures, first paragraph.	
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 1, under procedures, statement 1.	
B. The procedures for selecting a PCP and scheduling an initial health appointment;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 2.	
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 3.	
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 4.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for those services authorized by the Contractor;				
E. Member rights and responsibilities including reporting suspected fraud and abuse;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 5.	
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 6.	
G. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 7.	
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 8.	
I. Procedures for arranging EPSDT for persons under the age of 21 years;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 9.	
J. Procedures for obtaining access to Long Term Care Services;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 10.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 11.	
L. A list of direct access services that may be accessed without the authorization of a PCP;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 12.	
M. Information about procedures for selecting a PCP or	Full-2013	Full	This requirement is addressed in Policy MC-004	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;			Member Handbook on page 2, under procedures, statement 13.	
N. Information about how to access care before a PCP is assigned or chosen;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 2, under procedures, statement 14.	
O. A Member's right to obtain second opinion in or out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook addresses this requirement on page 2, under procedures, statement 15.	
P. Procedures for obtaining Covered Services from non-network providers;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 16.	
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 17.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 18.	
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 19.	
T. Information on the availability of health education services;	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 20.	
U. Information deemed mandatory by the Department; and	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 21.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
V. The availability of care coordination, case management and disease management provided by the Contractor.	Full-2013	Full	This requirement is addressed in Policy MC-004 Member Handbook on page 3, under procedures, statement 22.	
31.3 Second Opinions				
At the Member's request, the Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, or arrange for the Member to obtain a second opinion outside the network without cost to the Member. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Full-2013	Full	This requirement is addressed in Policy UM-014 Second Opinions on page 1.	
23.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) KY Enrollee Rights Summary Table-2015-Q3-DRAFT from the Desk Audit addresses this requirement (Q4 2015 results were not reviewed since they were not available at the time of the compliance review).	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7)	Full-2013	Full	The Member Handbook addresses this requirement on page 17.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) CC_Reports 15110, 150210, 150310, 150415, 150515, 150615, 150715, 150815, and 150915 address this requirement (Q4 2015 results were not reviewed since they were not available at the time of the compliance review).	
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.	Full-2013	Full	Language services are mentioned on page 44 of the Member Handbook. MC-001 Member Communication Standards addresses this requirement. Also addressed partially in MC-006 and MC-002.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.	Full-2013	Full	KYPR00039 Provider Manual cites ADA, safety and access to records. Member Handbook addresses requirement pertaining to Cabinet for Health and Family Services Ombudsman Program.	
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Full-2015	Full	Policy MC-008 Member Services addresses this requirement on page 1, statement A.	
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	New Requirement	Non-Compliance	CoventryCares should add this requirement to Policy MC-008 and/or in provider and member manuals. Upon onsite discussion, CoventryCares indicated it would be addressed in the provider/member manuals and in their Member Services Functions Policy.	
C. Guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.	New Requirement	Non-Compliance	CoventryCares should add this requirement to Policy MC-008. Upon onsite discussion, CoventryCares indicated it would be addressed in their Member Services Functions Policy.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Monitoring the selection and assignment process of PCPs;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement B.	
E. Identifying, investigating, and resolving Member Grievances about health care services;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement C.	
F. Assisting Members with filing formal Appeals regarding plan determinations;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement D.	
G. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement E.	
H. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement F.	
I. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement G.	
J. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 1, statement H.	
K. Explaining or answering any questions regarding the Member Handbook;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement I.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
L. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement J.	
M. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement K.	
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement L.	
O. Providing Members with information or referring to	Full-2015	Full	This requirement is addressed in Policy MC-008	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;			Member Services on page 2, statement M.	
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases.	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement N.	
Q. Facilitating access to behavioral health services and pharmaceutical services;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement O.	
R. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement P.	
S. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 2, statement Q.	
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 3, statement R.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
U. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 3, statement S.	
V. Facilitating access to Member Health Education Programs;	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 3, statement T.	
W. Assisting members in completing the Health Risk Assessment (HRA) upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 3, statement U.	
X. The Member Services staff shall be responsible for making an annual report to management about any changes needed in member services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Full-2015	Full	This requirement is addressed in Policy MC-008 Member Services on page 3, statement X.	
31.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
However, if a Member agrees in advance in writing to pay	Full-2013	Full	This requirement is addressed in the Provider	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.			Manual - Balance Bill/Hold Harmless: "In the event a member requests non-covered services, a provider may render non-covered services to a member so long as provider has obtained a detailed, easy to understand, request for such non-covered services stated clearly in writing and the member clearly understands and has been informed and acknowledged in writing that CoventryCares will not cover such services".	
24.0 Member Selection of Primary Care Provider (PCP)				
24.1 Members Not Required to have a PCP				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP.	Full-2013	Full	PCP Change Policy addresses this requirement on page 1, bullet 8.	
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a PCP for their medical home.	New Requirement	Full	PCP Change Policy addresses this requirement on page 1, bullet 1.	
The Contractor shall have two processes in place for Members to choose a PCP: A. A process for Members who have SSI coverage but are not Dual Eligible Members; and B. A process for other Members.	Full-2013	Full	PCP Change Policy addresses this requirement on page 1, bullets 1, 2 and 9.	
24.6 Primary Care Provider (PCP) Changes				

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.	Full-2013	Full	Member Handbook pages 21-22 and MC-008 bullet J addresses this requirement. Provider Manual also addresses this requirement, in detail, on page 44. Provider Termination (GA-008) addresses this requirement.	
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.	Full-2013	Substantial	Member Handbook addresses enrollee's right to change PCP on pages 21-22, however 10 day timeframe is not specified. In the 2013 compliance review, Policy GA-006 PCP Assignments was cited as fulfilling this requirement, however this document has been replaced by AP 006, as per onsite discussion with CoventryCares. Policy AP 006 was not uploaded to the FTP following the 2016 compliance review, and thus 10 day timeframe cannot be validated. **Recommendation for CoventryCares of**	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Kentucky It is recommended that Coventry add the ten (10) day requirement to its policy.	
A Member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the same Medicaid Region.	Full-2013	Substantial	This requirement Is partially addressed in the Provider Manual section "Procedure for Members to Change PCP", however there is no reference made to 90 day timeframe and member's right to change PCP once a year. In the 2013 compliance review, Policy GA-006 PCP Assignments was cited as fulfilling this requirement, however this document has been replaced by AP 006, as per onsite discussion with CoventryCares. Policy AP 006 was not uploaded to the FTP following the 2016 compliance review, and thus 90 day timeframe and member's right to change PCP once per year cannot be validated. **Recommendation to CoventryCares of Kentucky** It is recommended that Coventry add the ninety (90) day timeframe language to its policy.	
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month	Full-2013	Full	This requirement is addressed in the Provider Manual.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of the request.				
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
The initial PCP must serve until the new PCP begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The PCP shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Full-2013	Full	This requirement is addressed in the Provider Manual.	
31.5 Referrals for Services not Covered by Contractor				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Members for Non-Covered Services that shall provide for the transition	Full-2013	Full	Policy UM-048 Referral for Non-Covered Services addresses this requirement on page 1, under procedures.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.				

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Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	83	3		3
Total Points	249	6		0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.87**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Enrollee Rights and Protection: Enrollee Rights
Suggested Evidence

Documents

Policies/Procedures for:

- Member rights and responsibilities
- Member Handbook
- Choice of primary care provider
- PCP changes
- Referral for non-covered services provided by FFS Medicaid providers
- Second Opinions
- Required member services functions including, but not limited to, call center and medical call-in system
- Cost Sharing

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics (MCO Report #11)

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Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Full-2013	Full	The 2015 Marketing Plan addresses all requirements. Coventry has eight dedicated outreach counselors (one for each region) who work within the communities to support the homeless and members who are victims of domestic violence to educate them on the availability of services. The MCO provided 2015 monthly monitoring reports. These reports are submitted to the Senior Executive staff during monthly "Score Card" meetings.	
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.	Full-2013	Full	This requirement is addressed in the 2015 Marketing Plan. The MCO utilizes multiple methods to reach their members and community partners. The MCO provided 2015 monthly monitoring reports. These reports are submitted to the Senior Executive staff during monthly "Score Card" meetings. These reports detail the outreach events conducted by the MCO each month.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-2013	Full	This requirement is addressed in the Case Management for Homeless Members Policy (CM 020). Onsite the MCO provided evidence of the extent of its outreach including the frequency of activities and the effectiveness of these outreach attempts.	
23.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Full-2013	Full	This requirement is addressed in the Case Management for Homeless Members Policy (CM 020).	
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-2013	Full	This requirement is addressed in the Homeless Outreach Plan which includes how the plan utilizes community resources, such as shelters and clinics and face-to-face encounters. Onsite, the MCO provided evidence of its outreach to homeless shelters and the recent programs it has run including nutritional training and assistance with hygiene items.	
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.	Full-2013	Full	This requirement is addressed in the Case Management for Homeless Members Policy (CM 020). The MCO does not differentiate services for members who are homeless. The MCO addresses the requirement that transportation be made available to members on page 45 of the Member Handbook.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,	Full-2013	Full	This requirement is addressed in the Communication Barrier Interventions for Members Policy on page 1. The MCO utilizes the Flesch Kincaid readability standards to show compliance with this standard.	
be published in at least a 14-point font size, and	Full-2013	Full	This requirement is addressed in the Member Written Communication Standards Policy.	
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-2013	Full	This requirement is addressed in the Requests for Alternative Format Member Materials documentation.	
Font size requirements shall not apply to Member Identification Cards.	Full-2013	Full	This requirement is addressed in the Member Handbook. The Handbook provides a sample id card.	
Braille and audiotapes shall be available for the partially blind and blind.	Full-2013	Full	This requirement is addressed in the Requests for Alternative Format Member Materials documentation.	
Provisions to review written materials for the illiterate shall be available.	Full-2013	Full	This requirement is addressed in the Communication Barrier Interventions for Members Policy.	
Telecommunication devices for the deaf shall be available.	Full-2013	Full	This requirement is addressed in the Communication Barrier Interventions for Members Policy.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.	Full-2013	Full	This requirement is addressed in the Communication Barrier Interventions for Members Policy.	
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2013	Full	This requirement is addressed in the 2015 Marketing Plan which maintains that a hardcopy of the marketing materials is	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			updated annually while an online version is updated in real time and includes a list of participating providers.	
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.	Full-2013	Full	This requirement is addressed on page 5 of the 2015 Marketing Plan.	
In addition all Member materials concerning behavioral health, with the exception of written materials unique to individual Members, shall be submitted to DBHDID's Director of the Division of Behavioral Health for review prior to publication and distribution to Members.	Not Applicable - DMS has instructed Coventry to submit materials to DMS and the State will submit to DBHDID as needed.	Not Applicable	DMS has instructed Coventry to submit materials to DMS and the State will submit to DBHDID as needed.	
29.14 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.	Full-2013	Full	This requirement is addressed throughout the 2015 Marketing Plan. This requirement is communicated to the providers in the Provider Manual on pages 77, 78, 82 and 83. This requirement is communicated to the members in the Member Handbook on pages 28 and 46.	
The Contractor shall communicate such policies to Subcontractors.	Full-2013	Full	This requirement is communicated to the providers in the Provider Manual. The MCO's Translation and Interpreter Service Policy also addresses this	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement.	

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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	18			
Total Points	54			

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Member and Community Education Outreach Plan
Outreach plan for homeless persons
Member Handbook
Member informational materials
Policies/procedures for promoting delivery of services in a culturally competent manner and evidence of communicating these policies/procedures to subcontractors

Reports

Reports of outreach activities

IPRO
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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
39.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Full-2013	Full	This requirement is addressed in policy QI-015 Medical Record Documentation Review. Attachment 1 details the requirements of the documentation. Attachment 2 is a medical record assessment tool. Coventry Cares provided the 2015 Medical Record report as evidence of their oversight.	
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records.	Full-2013	Full	This requirement is addressed in Policy UM 031 Clinical Record Confidentiality and RR 002 Member Rights and Responsibilities.	
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Full-2013	Full	This requirement is addressed in Policy HIPAA 007, Accounting of Disclosures.	

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.	Full-2014	Full	This requirement is addressed in Policy UM 031 Clinical Record Confidentiality	
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.	Full-2013	Full	This requirement is addressed in Policy QI 015 Medical Record Documentation Review addressed this requirement. CoventryCares also provided the 2015 Medical Record Report as evidence of this requirement.	
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high	Full-2013	Full	This requirement is addressed in Policy QI 015 Medical Record Documentation Review.	

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:			CoventryCares' Quality Improvement department conducted the annual medical record audit in June 2015. 101 charts were reviewed at 25 PCP offices. Coventry also provided the Medical Record Report as evidence for this requirement	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;	Full-2013	Full	CoventryCares' Medical Record Report addresses this requirement as follows: All 25 of the practices received a passing score of 80% or above.	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full-2013	Substantial	While results of provider performance are not reported individually or plan-wide, the 2015 report does capture past findings, thereby trending audit results over time. Upon onsite discussion, Coventry Cares indicated that they are not able to run individual provider reports, since the sampling of providers that are audited changes year after year. They will, however, make an attempt to trend plan-wide. **Recommendation for CoventryCares of Kentucky** It is recommended that Coventry examine the way it tracks and trends individual and plan wide provider performance. **Final Review Determination** No change in review determination.	**MCO Response** The trending IPRO noted in the audit results "While results of provider performance are not reported individually or plan-wide, the 2015 report does capture past findings, thereby trending audit results over time." does in fact represent "plan-wide" performance. The providers sampled in our audit would be an equivalent rationale of using a sample size with our CAHPS survey, BH survey, or Provider satisfaction survey in that you select only a portion of your denominator to measure and trend results. The plan-wide trending is demonstrated in the annual report. Individual provider tracking procedures are outlined in the policy provided for this audit. Policy QI – 015 identifies in the procedure section, items #3, #4 and #6 outline the tracking of individual providers. The trending component of individual providers would then fall in to a credentialing process for

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The information in the MCO response is not reflective of the information cited above from the onsite interview. Additionally, the documentation provided by the MCO is not in compliance with the MCO's policy and procedure. Policy and procedure QI-015 Medical Record Documentation Review, states the following: - Providers will be sent a letter with findings within 30 days of the audit. - Providers with scores below 80% will receive a notification and/or CAP request. - Providers with CAP will be re-audited within 6 months. The report provided by the MCO does not indicate if any individual providers scored below 80% or below 70%, whether any CAP requests were issued and/or re-monitoring was necessary or occurred in 2015 as a result of the prior year's findings. The scores for overall compliance and individual elements are not reported for years prior to 2015, for purposes of trending. The MCO did not provide documentation of the letters sent to providers within 30 days of the audit, per policy and procedure.	any provider that is on a CAP. Per policy QM 54 (page 10 of 31) outlines the 'Recredentialing review performance monitoring' that indicates QM issue trend in the last 3 years in added to the recredentialing file.
C. Include mechanism and processes that allow for the identification, investigation	Full-2013	Full	CoventryCares' Medical Record Report addresses this requirement.	

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and resolution of quality of care concerns; and				
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	Full-2014	Full	Policy UM 017 addresses the requirement of under and over utilization. Upon onsite discussion inquiring about over/underutilization *by provider*, CoventryCares submitted an SIU data analysis work plan, which provided analysis of services being billed by provider. The report is given to internal investigator for further review and action. Monthly meeting is held, where minutes are taken, and new trends in over/under utilization are discussed.	
28.7 Provider Maintenance of Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment	Full-2013	Full	This requirement was addressed with the submission of sample contracts.	

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).	Full-2013	Full	This requirement is addressed in the Member Handbook page 6 and CoventryCares' policy for Record Retention also addresses this requirement.	
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Full-2013	Full	Policy QI 015 Medical Record Documentation Review, and the Provider Manual, addresses this requirement.	
A. Member/patient identification information, on each page;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 13.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 13.	
C. Date of data entry and date of encounter;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 13.	
D. Provider identification by name;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
G. Identification of current problems;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provider's initials or other documentation indicating review;				
I. Documentation of immunizations pursuant to 902 KAR 2:060;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
J. Identification and history of nicotine, alcohol use or substance abuse;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 14.	
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 15.	
L. Follow-up visits provided secondary to reports of emergency room care;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 15.	
M. Hospital discharge summaries;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 15.	
N. Advanced Medical Directives, for adults;	Full-2013	Full	This requirement is addressed in the Provider Manual on page 84.	
O. All written denials of service and the reason for the denial; and	Full-2013	Full	This requirement is addressed in the Provider Manual on page 15.	
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.	Full-2013	Full	This requirement is addressed in the Provider Manual on page 13.	
A Member's medical record shall include the following minimal detail for individual				

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clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	Full-2015	Full	This requirement is addressed in the Provider Manual in the medical record standards section. This requirement is also addressed in QI 015.	
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and	Full-2013	Full	This requirement is addressed in the QI Medical Record Assessment Tool. The requirement is also addressed in the Provider Manual on page 14.	
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	Full-2015	Full	This requirement is addressed in the Provider Manual on page 14.	
28.8 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills	Full-2013	Full	This requirement is addressed in the Provider Manual on page 84. This is also addressed in the Member Handbook, page 26.	

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.	Full-2013	Full	This is addressed in the Provider Manual on page 84. This is also addressed in the Member Handbook, page 26.	
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.	Full-2013	Substantial	This requirement is addressed in the Provider Manual on page 84. This is also addressed in the Member Handbook, page 26. However, it is not clearly stated that it should be on the first medical appointment. **Recommendation for CoventryCares of Kentucky** The "first" medical appointment should be specified in the advance directives section of Provider Manual. **Final Review Determination**	**MCO Response** No comment. We can update this.

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			No change in2015 review determination.	
39.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 41.15.	Full-2013	Full	Policy UM 031 Clinical Record Confidentiality addresses this requirement.	
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact	Full-2013	Full	Policy UM 031 Clinical Record Confidentiality partially addresses this requirement. Upon onsite discussion, CoventryCares submitted a Desktop Procedure ("Disclosure of Information Related to a Minor") that addresses this requirement.	

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to the home.				
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-2013	Full	While onsite, CoventryCares provided several examples of confidentiality agreements signed on behalf of their employees.	
Except as otherwise required by law, regulations or this Contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.	Full-2013	Full	This requirement is addressed in Policy HIPAA 003 Business Associates, and in Policy PRIVACY 001.	
41.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract	Full-2013	Full	This requirement is addressed in Policy HIPAA 003 Business Associates, and in Policy HIPAA-007 Accounting of Disclosures.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
entered by the Contractor as a result of this agreement shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as are the Contractor.				

IPRO
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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	38	2	0	0
Total Points	114	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.95**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Medical Records
Suggested Evidence

Documents

Policies/procedures for:

- Confidentiality/HIPAA
- Access to medical records
- Transfer of records
- Medical records and documentation standards
- Process and tools for assessing/monitoring provider compliance with medical record standards including performance goals
- Advance Medical Directives

Sample contracts between MCO and network providers and subcontractors demonstrating provisions for medical records and documentation standards; and confidentiality/HIPAA requirements
Member materials related to Advance Directives
Provider materials related to Advance Directives
Evidence of signed confidentiality agreement on behalf of employees, agents and assigns

Reports

Provider compliance assessment/monitoring results and follow-up

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Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.2 Requirements for Behavioral Health Services				
The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Members with SMI and SED, including Members with co-occurring developmental disabilities, substance use disorders and smoking cessation. The Contractor in its design and operation of behavioral health services shall incorporate these core values for Medicaid Members: A. Members have the right to retain the fullest control possible over their behavior health treatment. Behavioral health services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare. B. The Contractor shall provide the most normative care in the least restrictive setting and serve Members in the community to the greatest extent possible. C. The Contractor shall measure Members' satisfaction with the services they receive. D. The Contractor's behavioral health services shall be recovery and resiliency focused.	Full-2013	Full	This requirement is addressed in the 2016 Behavioral Health Provider Quick Reference Guide (QRG) and the MHNet UM Manual, Chapter 4 Triage, Assessment and Referral, Chapter 9 Coordination of Care, and Chapter 15 Care Management and Complex Care Management.	
34.3 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix H.	Full-2013	Full	This requirement is addressed in MHNet UM Manual, Chapter 4 Triage, Assessment, and Referral, 2015 MHNet Provider QRG.	
All Behavioral Health services shall be provided in	Full-2013	Full	This requirement is addressed in MHNet	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM.			UM Manual, Chapter 4 Triage, Assessment, and Referral, 2015 MHNet Provider QRG, 2015 Provider Manual, and the MHNet Network Accessibility Analysis 2015.	
Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.	Full-2013	Full	This requirement is addressed in the 2015 MHNet Provider QRG, MHNet Practitioner Treatment Record Review Tool.	
34.4 Behavioral Health Provider Network				
The Contractor shall provide access to Psychiatrists, Psychologists, and other behavioral health service providers.	Full-2013	Full	This requirement is addressed in sample BH provider contracts and the 2015 MHNet Provider QRG, credentialing requirements for various practitioner types. This requirement is demonstrated in the MHNet Network Accessibility Analysis 2015.	
Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations,	Full-2015	Full	This requirement is addressed in sample BH provider contracts and the 2015 MHNet Provider QRG. This requirement is demonstrated in the MHNet Network Accessibility Analysis 2015.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Licensed Clinical Social Workers, Certified Family, Youth and Peer Support Providers, Targeted Case Managers and other independently licensed behavioral health professions.				
To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full-2013	Full	This requirement is addressed in sample BH provider contracts. This requirement is demonstrated in the MHNet Network Accessibility Analysis 2015.	
34.5 Member Access to Behavioral Health Services				
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full-2015	Full	This requirement is demonstrated in the MHNet Network Accessibility Analysis 2015.	
In order to ensure such accessibility, the Contractor shall submit credentialing documents for no fewer than five hundred (500) independent behavioral health individual providers distributed throughout the state, not including providers linked or affiliated with the following licensed organizations: a CMHC, a BHSO, a FQHC, or a RHC, on or by January 1, 2016.	New Requirement	Full	This requirement is demonstrated in the MHNet Network Accessibility Analysis 2015.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services. The Member Manual shall contain information for Members on how to direct their behavioral health care, as appropriate.	Full-2013	Full	This requirement is addressed in the 2015 MHNet UM Manual, Chapter 15, Care Management and Complex Care Management, 2015 Member Handbook and the 2015 MHNet Provider QRG.	
The Contractor shall permit Members to participate in	Full-2013	Full	This requirement is addressed in MHNet	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.			UM Manual, Chapter 4 Triage, Assessment, and Referral.	
34.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth.	Full-2013	Full	This requirement is addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls, 2015 Member Handbook 2015 MHNet Provider QRG. Evidenced in MCO Reports #11 Call Center.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full-2013	Full	This requirement is addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls.	
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full-2013	Full	Addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls and section 4.8 Emergency Services.	
It is not acceptable for an intake line to be answered by an answering machine.	Full-2013	Full	Evidenced in 2015 monthly MCO Reports #11 Call Center.	
The Contractor shall ensure that the toll-free Behavioral	Full-2013	Full	Includes review of MCO Report #11 Call	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Health Services Hotline meets the following minimum performance requirements for all Contractor Programs:			Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
B. No incoming calls receive a busy signal;	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
D. The call abandonment rate is seven percent (7%) or less;	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
E. The average hold time is two (2) minutes or less; and	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review. Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Full-2013	Full	Addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls.	
The Contractor may operate one hotline to handle	Full-2013	Full	Addressed in policy and procedure	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
emergency and crisis calls and routine Member calls.			MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls.	
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	Full-2014	Full	Addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls. Evidenced in MCO Report #11 Call Center.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Full-2013	Full	Addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls.	
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.	Full-2013	Full	Addressed in policy and procedure MHNet UM Manual, Chapter 4 Triage Assessment and Referral, section 4.4 Crisis Calls.	
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2013	Full	Evidenced in MCO Report #11, January – September 2015.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2013	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Q4 2015 desk audit results were not reviewed since it was not available at the time of the review.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Per MCO Report #11, all required metrics were met or exceeded for 2015 to date.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.	New Requirement			
34.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department and DBHDID for approval. The Contractor will work directly with DBHDID to introduce the evidence based tool Screening, Brief Intervention, Referral, and Treatment (SBRIT) in appropriate PCP settings.	Full-2013	Full	Addressed in the 2015 Provider Manual, section I. Primary Care Providers, and Responsibilities of Primary Care Providers and sample provider contracts.	
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health	Full-2014	Full	Addressed in the 2015 Provider Manual, and 2015 MHNet Provider QRG.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
screening techniques for PCPs and new models of behavioral health interventions.				
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Substantial - The Provider Newsletter First Quarter 2014 on page 5 addresses this requirement. The MHNet Contract on page 4 states that the practitioner agrees to comply with state and federal regulations and MHNet's policies, including, but not limited to, those pertaining to continuity and quality of care, medical management, etc. The MHNet Behavioral Health Provider Quick Reference Guide on pages 8 and 13 address this requirement. The MHNet Utilization Improvement Manual on pages 6-7 and 205 address this requirement. On pages 113-114, Chapter 5 Managing Ongoing Care provides the procedure for initiating behavioral health care management. This includes at least 2 phone attempts at different hours of the day, mailed letter, call attempt 10 days after the letter, and efforts to obtain alternate member contact information from providers, and health plan care manager. CoventryCares Provider Manual on page 22 states that PCP's responsibilities include: to provide, coordinate and/or direct all health care	Full	Includes BH/PH Care Coordination file review summary results Addressed in the 2015 Provider Manual, 2015 MHNet Provider QRG, and sample provider contracts, and MHNet UM Manual, Chapter 9, section 9.3 – Continuity and Coordination of Care, and Chapter 4 Care Management and Complex Care Management. <u>BH/PH Care Coordination File Review Results</u> 10 files were reviewed. All files were fully compliant	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	needs of members to maintain continuity of care. Additionally, on page 49 it states that PCPs can also contact MHNet for assistance in facilitating specialty behavioral health services for members. MHNet will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatry services. <u>BH/PH Care Coordination File Review Results</u> 10 files were reviewed. 7 of 10 files included a comprehensive assessment with the required components. The remaining 3 files were not applicable as the member was unreachable or refused services. 5 of 10 files included a care plan with the required components. The remaining 5 files were not applicable. 6 of 10 files included identification of the PH and BH needs of the member and facilitation and coordination of needed services; the remaining files were not applicable. 1 of 10 files showed need for follow-up/rescheduling of missed appointments and follow-up was documented. 2 of 10 members were hospitalized and participation in discharge planning was evident in one file. The second file was a member that			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	had been hospitalized from 3/6/14-3/12/14 for a suicide attempt with first note dated 3/20/14. 4 of 10 files evidenced information sharing, other than the initial referrals from/to behavioral health care management. 4 files were not applicable. In one file, MHNet documented that the member stated they were out of 2 medications for seizure disorder and member was advised that they would let the medical care manager know and she would probably call member. The next MHNet note is 2 months later indicating that the member had all medication. Although there appears to have been communication between CoventryCares and MHNet, it wasn't documented in the record. Additionally, in another file the referral to MHNet was documented on 6/20/14. On 9/4/14 the medical care manager discussed the need for a mental provider with the member and it was noted that referral had been made however member reported never receiving a call. CoventryCares care manager did a 3 way call to MHNet to get information about services. There was no MHNet documentation during this timeframe. Note: Documentation was available from the CoventryCare medical record, but very little documentation from MHNet. Many cases ended after one outreach attempt			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	with UTC and a letter sent or care manager spoke with member with no further documented outreach conducted. During the onsite interview it was explained that MHNet employees were not functioning as care managers, but mainly as prior authorizations employees. The employees are in a transition phase and being integrated. All employees are receiving education for behavioral health care management and medical care management. **Recommendation for CoventryCares:** CoventryCares/MHNet should address the following: - Ensure that more than one outreach attempt is made for members referred for BH issues. - Ensure that the care manager participates in discharge planning if the member has been hospitalized. - Files should contain documentation of information sharing between physical health and behavioral health, monitoring of diagnosis, treatment, and follow-up and medication usage. **MCO Response:** The MHNet utilization manual chapter 9 has been updated to state two outreach attempts are made for members referred for BH issues. The MHNet utilization manual chapter 6 has been updated to include that the care manager			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	participates in discharge planning if the member has been hospitalized. The Coordination of Care Screening form has been updated and is part of the members file to share information between physical health and behavioral health.			
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full-2013	Full	Addressed in the 2015 MHNet Provider QRG and MHNet sample provider contracts.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.	Full-2013	Full	Addressed in the 2015 MHNet Provider QRG and MHNet sample provider contracts.	
34.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Full-2013	Full	Addressed in MHNet sample provider contracts.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full-2013	Full	Addressed in MHNet sample provider contracts, MHNet Protocol for Members Discharged from State Hospital. Evidenced in HEDIS 2015 Follow up After Hospitalization for Mental Illness, 7-day and 30-day follow up.	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Minimal - The CoventryCares of Kentucky Provider Manual on page 28 does not include the following elements: Behavioral health Service Providers or attempts should occur within twenty-four (24) hours to reschedule appointments. The MHNet Utilization Management Program Description on page 8 discusses Care Management re-contacting the member and assisting in re-scheduling additional follow-up appointments when discharged from an acute setting. Additionally, a timeframe is not indicated. The MHNet Behavioral Health Provider Quick Reference Guide states that there is a protocol/process for documenting communication or attempted communication with the member following a missed appointment, but no timeframe noted. The MHNet Utilization Improvement Manual on page 129 discusses, but does not include a	Substantial	Addressed in the sample MHNet provider contracts. **Recommendation for CoventryCares of Kentucky** Although this requirement is addressed in the provider contracts, Coventry should add the timeframe (24 hours) as a Kentucky-Medicaid-specific requirement to the MHNet Provider QRG, Kentucky Medicaid addendum as well the MHNet UM Manual, Chapter 4 Triage, Assessment and Referral, missed appointments.	MCO did not provide a response.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	timeframe. Following the onsite review, the MCO provided a recently revised copy of Continuity and Coordination of Care (CM – 035) which includes the language that Behavioral Health Service providers will contact members who have missed appointments within (24) hours to reschedule appointments. **Recommendation for CoventryCares:** The policy revisions should be approved and implemented. **DMS Response:** Since IPRO recommended that the policy be updated in the previous three compliance reviews, an LOC /CAP maybe issued. **MCO Response:** Continuity and Coordination of Care (CM – 035) which includes the language that Behavioral Health Service providers will contact members who have missed appointments within (24) hours to reschedule appointments has been updated and approved by the plan.			
34.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric	Full-2013	Substantial	Addressed in sample provider contract,	MCO did not provide a response.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.			State Operated Psychiatric Hospital. **Recommendation for CoventryCares of Kentucky** Although this is addressed in the facility contracts, Coventry should add this requirement to its MHNet UM Manual.	
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Full-2014	Substantial	Addressed in sample provider contract, Facility/State Operated Psychiatric Hospital. **Recommendation for CoventryCares of Kentucky** Although this is addressed in the facility contracts, Coventry should add this requirement to its MHNet UM Manual.	MCO did not provide a response.
34.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
A. The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law and/or voluntarily admitted to the state psychiatric hospital.	Full-2013	Full	Addressed in MHNet Protocol for Members Discharged from State Hospital.	
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law.	Full-2013	Full	Addressed in sample provider contract, Facility/State Operated Psychiatric Hospital and MHNet Protocol for Members Discharged from State	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.			Hospital.	
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.	Full-2013	Full	Addressed in MHNet Protocol for Members Discharged from State Hospital.	
B. The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness (SMI) and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.	Full-2013	Full	Addressed in MHNet Protocol for Members Discharged from State Hospital.	
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.	Full-2013	Full	Addressed in MHNet Protocol for Members Discharged from State Hospital.	
Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a	Full-2013	Full	Addressed in MHNet Protocol for Members Discharged from State Hospital.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full-2013	Full	Addressed in the MHNet Protocol for Members Discharged from State Hospital.	
34.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Full-2013	Full	Addressed in the MHNet UM Manual, Chapter 4, Triage, Assessment and Referral and the 2015 MHNet Provider QRG Guidelines and availability are addressed in the 2015 MHNet Provider QRG and in the Kentucky Medicaid addendum. Accessibility is addressed in the 2015 MHNet Provider QRG, the Kentucky Medicaid addendum, and the 2015 MHNet Network Accessibility Analysis.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug	Full-2014	Full	Addressed in the MHNet UM Manual, Chapter 15, Care Management and Complex Care Management.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reactions;				
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;	Full-2013	Full	Addressed in the MHNet UM Manual, Chapter 15, Care Management and Complex Care Management and Chapter 9 Continuity and Coordination of Care.	
D. Protect the confidentiality of Member information and records; and	Full-2013	Full	Addressed in the MHNet UM Manual, Chapter 15, Care Management and Complex Care Management.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2013	Full	Addressed in the Addressed in the MHNet UM Manual, Chapter 9 Continuity and Coordination of Care. Evidenced in the 2015 MNNet Provider QRG, MHNet Practitioner Treatment Record Review Tool, and the MNNet Quality Improvement Program Description, MHNet QIC/UIC Work Schedule and MCO report #85 2014 Coventry QI Program Evaluation.	
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

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Final Findings

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	47	3		
Total Points	141	6		

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.94**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

- Behavioral Health services
- Clinical coordination between BH services providers and PCPs
- BH provider program capacity requirements
- BH services hotline
- Court-ordered services
- Case management services for members including discharge planning
- Accessing free or discounted medication

Benefit Summary (covered/non-covered BH services)
Provider Manual
Sample PCP contract
Sample BH provider contract
Process for educating members of where and how to obtain BH services
Process for monitoring compliance with hotline requirements
Process for educating PCPs of BH services/requirements
Evidence of training of PCPs regarding BH services/requirements
Sample participation agreement with CMHCs
Sample collaborative agreement with state operated or state contracted psychiatric hospitals
Process for coordination of services for members committed by court of law to the state psychiatric hospital
Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services
Process for facilitating the exchange of pharmaceutical information among providers
Process for evaluating continuity and coordination of care among providers
QI Plan
Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Final Findings

Reports

Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements (MCO Report #11)
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

File Review

BH/PH Coordination files for a random sample of cases chosen by EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.1 Pharmacy Requirements				
The Contractor shall administer pharmacy benefits in accordance with this section in addition to other requirements specified in this contract, and in accordance with all applicable State and Federal laws and regulations. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review (ProDUR);	Full-2013	Full	This requirement is addressed in the Pharmaceutical Management Procedures, Processes, Development and ongoing Management of Formularies, #8, Drug Utilization Review, page 7.	
B. An accounts receivable process;	Full-2013	Full	This requirement is addressed in the Aetna Sarbanes Oxley Narrative-CVH Pharmacy Rebate Receivables, Overview, page 1.	
C. Retrospective drug utilization review (RetroDUR) services;	Full-2013	Full	This requirement is addressed in the Drug Utilization Management policy, Procedures, 1.b., page 2.	
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, an appeals process, Preferred Drug List (PDL), and a Pharmacy and Therapeutics Committee Meeting (P&T);	Full-2013	Substantial	Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports. Q4 2015 results were not reviewed since they were not available at the time of the compliance review). This requirement is addressed in the	**MCO Response** The appeal process is a concise product of the appeals department. The member receives upon an adverse determination of a benefit a notification letter of the complete appeals process as required by the contract of KY DMS. The plan believes this fulfills the deficiency as noted by the EQRO reviewers as well as best serving the members need for information at the time of

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Pharmaceutical Management Procedures, Processes, Development and ongoing Management of Formularies on page 2, however the Policy failed to include an appeals process. This requirement of Prior Authorizations is addressed in Report #59. **Recommendation for CoventryCares** Appeals process should be explained and/or outlined in the Pharmaceutical Management Procedures. **Final Review Determination** No change in review determination. This element addresses the requirements for the MCO's pharmacy benefit program, specifically. Information to the member and members' rights are not the specific focus of this element. It is understood that appeals are a discrete function of the Appeals Department; however, appeals, as they relate to pharmacy benefits, should be addressed in the pharmacy	notification. Secondly the member handbook which each member has or is available to the member on the web site also provides complete appeals information. This information is also repeated within the provider's manual.

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			program documents, even if it is simply a statement that pharmacy appeals are managed by the MCO's appeal department as for any other benefit with a reference to the appeals policies and procedures.	
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Full-2013	Full	The requirement of training and education is addressed in the Drug Utilization Management procedure, 4. Associate Training and Education, page 3-4. The requirement of Call Centers is addressed in the Commercial and Medicaid/Inter-Rater Reliability Audits, Procedure, page 2.	
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Full-2013	Full	This requirement is addressed in the Retail Pharmacy Audit Program, Audit Program Overview, and Audit Selection, pages 1-2.	
G. Claims payment services;	New Requirement	Full	This requirement is addressed in the Retail Pharmacy Audit Program, Audit Program Overview, and Audit Selection, page2.	
H. The Contractor shall maintain, through an online system, appropriate accounts receivable (AR) records for the Department to systematically track adjustments, recoupments, manual payments, and other required	Full-2013	Full	This requirement is addressed in Report #39 template.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
identifying AR and claim information;				
I. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	New Requirement	Full	This requirement is addressed in the Pharmaceutical Management Procedures Policy, Processes, 1.c, and pages 2-3.	
J. Coverage for all drugs for which a federal rebate is available per USC § 139BR-8 unless otherwise directed by the Department;	Non-Compliance - The Technology Assessment (7000.20) policy did not include language pertaining to the coverage for all drugs for which a federal rebate is available. During the onsite review, the MCO provided a revised copy of Pharmaceutical Management Procedures (RX-1003) revised on 2/2015 which meets the contract language.	Full	This requirement is addressed in the Pharmaceutical Management Procedures, Processes, 3d, page 4.	
K. All hand-written or computer generated/printed Medicaid prescriptions shall require at least one (1) approved tamper-resistant feature to prevent copying; modification or erasure; or counterfeiting. This requirement does not pertain to prescriptions received by fax, telephone, or electronically; and	New Requirement	Substantial	This requirement is partially addressed in the Retail Pharmacy Audit Program, Types of Audits, Field Audits, page 3. This policy states: "Verify that a paper prescription exists for all prescription claims reviewed and that the drug names, strengths and quantities billed are in accordance with the physician's	**MCO Response** The plan is completely aware of the stipulations and requirements for prescriptions to meet the KY DMS requirements. **It is also noted that the web site for CMS "Med learns" https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0736.pdf**

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			prescription order." **Recommendation for CoventryCares** This language should be stated in Pharmacy Audit Program. **Final Review Determination** No change in review determination. Note that this is a new requirement. Regardless of CMS guidelines for Medicare and licensing requirements for pharmacists and prescribers, this requirement is specifically stipulated in the MCO contract with DMS, and therefore; must be included in the MCO's program documents as part of the pharmacy audit program, along with the other routine elements for field audit.	**States clearly that the managed care payment exempts the prescriptions from this element.** Secondly, As the pharmacist and the prescriber are licensed within the state for practice and credentialed based on state licensure this element is fulfilled with the acceptance of the pharmacist and the creation of the prescriber. The plan believes this finding should relate to a full acceptance in the EQRO review. The Plan, however also appreciated the suggestion for the incorporation of auditing to this compliance efforts by the state which will be done as recommended.
L. The Contractor shall also assist the Department by participating in and providing support during internal and external audits, including CMS certification of the Kentucky MEMS.	New Requirement	Non-Compliance	No documentation was provided by the plan to meet this requirement. **Final Review Determination** No change in review determination. Note that this is a new requirement, and as such, an affirmative statement that the MCO will assist and support	**MCO Response** The plan believes this statement of non-compliance is unwarranted based on the numbers and volumes of state required reports that are filed monthly, quarterly and annually. These are known to be rolled up to the CMS needed purposes to support KY DMS in compliance to CMS requirements. We have also filed and supported the states effort as requires to for multiple

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the department should be addressed in the MCO's program documents.	programs due to the state's needs. Programs affiliated with the other MCO's are typical examples. The plan has always actioned the resources needed to support the states requests. Samples of these may be provided as needed.
32.2 Preferred Drug List				
The Contractor shall maintain a preferred drug list (PDL) and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.	Full-2013	Full	This requirement is addressed in the Pharmaceutical Management Procedures, Processes, 5 a. & b., pages 5-6.	
The Contractor shall provide information to its pharmacy and prescribing Providers regarding the PDL, for Members via posting on the web and other relevant means of communication. This PDL shall be updated by the Contractor throughout the year and shall reflect changes in the status of a drug or add or delete drugs, as required.	Full-2013	Full	This requirement is addressed in the Pharmaceutical Management Procedures, Processes, 5 a. & b., pages 5-6.	
32.3 Pharmacy and Therapeutics Committee.				
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T Committee shall be considered an advisory committee to a public body and thereby making it subject to the Open Meetings Law. The Contractor shall give prior notice to the Department of the time, date and location of the P&T Committee meetings.	Full-2013	Full	This requirement is partially addressed in the UM Program Description 2015, CoventryCares of Kentucky Committees, Pharmacy and Therapeutics Committee (P&T), pages 16-17. The requirement of giving the Contractor notice of a Public Meeting is addressed in the National Pharmacy & Therapeutics Committee, 3.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Proceedings of the National P&T Committee Meetings, f., page 5.	
32.4 Point of Sale and Claims Payment				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain ProDUR review edits and apply these edits at the POS.	Full-2013	Full	This requirement is addressed in the Pharmaceutical Management Procedures, Processes, Development and ongoing Management of Formularies, #8, Drug Utilization Review, page 7.	
32.5 Pharmacy Rebate Administration				
The Affordable Care Act requires states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. The Department or its designated contractor will provide this claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Full-2013	Full	Requirement addressed in Pharmacy_Receivables_Narrative as well as Pharmacy Rebate Policy RXR-1.	
38.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization	Full-2013	Full	Includes review of the following MCO	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.			Reports: #40A Top 50 Psych Drugs by Quantity Reimbursed #40B Top 50 Psych Drugs by Reimbursement #42A Top 50 Prescribers by Reimbursement #42B Top 50 Prescribers of Controlled Drugs by Reimbursement #42C Top 50 BH Prescribers by Reimbursement #43 Top 50 Controlled Drugs by Quantity Reimbursed #44 Top 50 Drugs by MCO Reimbursement #45A Top 50 Drugs by Quantity #45B Top 50 Non PDL Drugs by Reimbursement (see Quarterly Desk Audit Reports. Q4 2015 results were not reviewed since they were not available at the time of the compliance review). This requirement is partially addressed in the Pharmaceutical Management Procedures, Processes, Development and ongoing Management of Formularies, #8, Drug Utilization Review, page 7. This requirement is partially addressed in the Drug Utilization	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Management policy, Procedures, 1.b., page 2. This requirement is confirmed by Reports # 40A, 40B, 42A, 42B, 42C, 43, 44, 45A, and 45B.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: CoventryCares of Kentucky

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	15	2	0	1
Total Points	45	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.72**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings
Pharmacy Benefits
Suggested Evidence

Documents

Policies/procedures for:

- Pharmacy benefit requirements
- Structure of pharmacy program
- Pharmacy claims administration
- Pharmacy rebate administration
- Prospective and retrospective drug utilization review
- Pharmacy restriction program
- Medicaid prescriptions

Preferred Drug List
Listing of drugs requiring prior authorization
Pharmacy & Therapeutics Committee description, membership, meeting agendas and minutes
Process for informing members and pharmacy providers of preferred drug list and related information
Process for evaluating the impact of the pharmacy program on members
Prior authorization process
Process for monitoring and managing the pharmacy program

Reports

Evidence of reporting and analysis of the pharmacy program to ensure compliance with Federal and State requirements
Monthly Formulary Management (MCO Report #39)
Prior Authorizations (MCO Report #59)
Top 50 Psych Drugs by Quantity Reimbursed (MCO Report #40A)
Top 50 Psych Drugs by Reimbursement (MCO Report #40B)
Top 50 Prescribers by Reimbursement (MCO Report #42A)
Top 50 Prescribers of Controlled Drugs by Reimbursement (MCO Report #42B)
Top 50 BH Prescribers by Reimbursement (MCO Report #42C)
Top 50 Controlled Drugs by Quantity Reimbursed (MCO Report #43)

Final Findings

Top 50 Drugs by MCO Reimbursement (MCO Report #44)

Top 50 Drugs by Quantity (MCO Report #45A)

Top 50 Non PDL Drugs by Reimbursement (MCO Report #45B)