KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana CareSource

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	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.		Humana indicated that for Kentucky Medicaid, policies and procedures will be revised to be co-branded. This will be limited to Kentucky Medicaid and will not include corporate policies affecting all lines of business (e.g. human resources policies). Since the co-branding is not a material change to policies and procedures affecting the services offered to members or treatment of providers, the annual schedule of review will be utilized to implement these internal revisions.	
The Contractor shall implement and operate a comprehensive QAPI program that assesses, monitors, evaluates and improves the quality of care provided to Members.	Substantial - Assessment, monitoring, evaluation and improvement activities are described throughout the Humana CareSource (OH-KY) and Humana local market (KY) program	Full	Addressed in the 2014 Quality Improvement (QI) Program Description, which describes the program overviews, goals, monitoring and evaluation process, governance, committees, resources, behavioral health aspects, provider participation, cultural and linguistic	

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**
	descriptions: • 2013 Quality Improvement Program, Humana CareSource (overview p. 6-9) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Approved 11.8.13. (overview p. 3-4) Implementation is addressed by the Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013. • It is noted 2013 was a start-up year; baseline data was collected, with performance measurement planned for 2014. • Empty table shells for 2013 and 2014 measurement (e.g., HEDIS, Access and Availability, CAHPS,		appropriateness, health information system, and program activities. The QI Program Description, pages 8-15, describes the organizational structure of the program. The Quality Assessment Committee (QAC) reports to the Humana East Division Quality Management Committee/Humana Corporate Quality Improvement Committee (CQIC) which reports to the Humana Board of Directors (BOD). The QAC also reports to the CareSource Quality Enterprise Committee (QEC). Various sub-committees related to areas such as delegation, care management, utilization management, grievance and appeals, pharmacy and therapeutics report to the QEC and QAC. The QI Program Description, pages 24-38, describes key performance measures and frequency of monitoring. For this review, rather than several separate documents, Humana prepared and submitted a single 2014 QI Program Description for the Humana-CareSource Kentucky MCO which clearly and consistently describes the committee structure, reporting relationships and responsibilities.	

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**
	Provider Satisfaction) were provided, as were barriers based on experience and improvement plans. • Limited available 2013 data included summary numbers for service operations calls, grievances, and appeals. • However, quarterly QAC (Quality Assessment Committee) minutes and QAPI Work Plan updates show reporting, analysis (categorization and trending), discussion and planning around quality of care metrics. Per the Humana KY Market Addendum org chart the committee structure is: Corporate QIC East Division (ED) QMC Humana CareSource QAC (Quality Assessment Committee) CareSource QEC (Quality Enterprise Committee)		Evidenced in the QI Work Plan and updates, which contain the indicator (activity/task), scope, responsible person, objectives, goals, target dates, related committee, issues identified, actions taken and analysis/assessment for each key QI function/activity. • Evidenced in the 2014 QI Program Annual Evaluation, which includes an assessment of the effectiveness of all key clinical and non-clinical QI activities, a description of the Performance Improvement Projects (PIPs) in process, and an overall assessment of the program progress.	

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**
	Per the Humana CareSource QAC charter, QAC reports both to the ED QMC and the CS QEC. The QAC is not described in either program description (found only in the Humana org chart). The org charts vary between the 2 program descriptions. The relationships seemed to be evolving per the minutes. Quality program activities are conducted at the market level and are the responsibility of both CareSource and Humana. Humana owns the network and retains peer review, quality of care investigations. CareSource has delegated/partnered with Beacon for BH. The above discrepancies and the Program Descriptions were discussed with the MCO during the onsite interview. The MCO			

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**
	reported that the 2014 description includes these committees and the reporting relationships. The QAC reporting relationship is as follows: QAC>Humana East Division QMC>Humana Corp QIC.Humana Board; ;and QAC>CareSource Q Enterprise Committee> CareSource Board **Recommendation for Humana CareSource** Organizational charts and Program Descriptions should clearly and consistently describe the committee structure, reporting relationships and responsibilities. **MCO Response:** Humana - CareSource agrees with the recommendation. A side by side comparison of HCS organizational chart including committee			

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**
	descriptions and the Humana KY Market Addendum organizational chart including committee descriptions will be conducted by the CareSource QI Manager and the Humana Regional QI Manager, East Region, and updates made to both documents as needed.			
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 - Processes to evaluate access, continuity, outcomes and services are addressed throughout several documents. • 2013 Quality Improvement Program, Humana CareSource • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013 • 2013 HCS QAPI Work Plan	Full	Addressed in the 2014 QI Program Description and the 2014 QI Work Plan which include processes and activities to evaluate access to care, continuity of care, health care outcomes, and services provided via the following metrics: Behavioral health (BH) care management, medical management and call center; HEDIS reporting, and Healthy Kentuckian (HK) Performance Measures. The MCO conducts monthly monitoring of performance metrics, quarterly trend analysis and annual analysis & evaluation. Evidenced in the 2014 QI Work Plan and 2014 QI 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**
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - Structures and processes are defined in: • 2013 Quality Improvement Program, Humana CareSource (p. 9-15) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Page 5-13 describes the relationship between: o Humana Corporate Quality Committee o Humana East Division Quality Management Committee o Humana CareSource Quality Assessment Committee o CareSource Quality Enterprise Committee ("a delegated vendor for Quality	Full	Addressed in the 2014 QI Program Description and 2014 QI Work Plan. As noted above, the QI program organizational structure is described on pages 8-15. The QAC reports to the CQIC, which reports to the BOD and also reports to the QEC. Various sub-committees related to areas such as delegation, care management, utilization management, grievance and appeals, pharmacy and therapeutics report to the QEC and QAC. Evidenced in the 2014 QI Work Plan and the 2014 QI 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**
	Operations for the Kentucky Medicaid Contract") Refinement of processes between the entities is noted throughout the first year's QAC minutes.			
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 by the Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013. As noted, 2013 was a start-up year. Although unable to demonstrate linkage of QI activities to findings from specified evaluation sources, barrier analysis / ongoing and planned activities were based on previous experience. QAC minutes demonstrate activity around delegate/internal surveillance results: Beacon, MCNA, pharmacy, UM, grievance and appeals.	Full	Addressed in the 2014 QI Program Evaluation which describes the range of activities in 2014, the outcomes and goals, as well as in the 2014 QI Work Plan which provides updated information on all activities quarterly. Humana has had limited opportunity to link findings from multiple evaluations and measurements, since reporting year (RY) 2014/measurement year (MY) 2013 was the first year/baseline reporting for both HEDIS, CAHPS, and the HK Performance Measures. In addition, since the MCO expanded its service area from Region 3 only to statewide, RY 2015/MY 2014 will be considered a new baseline measurement. The MCO did report plans to link CAHPS results with the planned/Q4 2014 PCP availability Secret Shopper survey by the Myers Group.	

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**
	Discussion of the linkage of QI activities to multiple evaluation sources is found throughout: • 2013 Quality Improvement Program, Humana CareSource • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Approved 11.8.13. • 2013 HCS QAPI Work Plan		**Recommendation for Humana** Going forward, Humana-CareSource should link findings from various measurements and evaluations to identify opportunities for improvement. For example, synthesizing provider grievances, the Provider Satisfaction Survey results, and provider appeals data may indicate issues with pharmacy authorizations/formulary and the need for provider education or member grievances, GeoAccess data, and CAHPS results can be compared and used to assess overall network adequacy.	
The QAPI program shall be developed in collaboration with input from Members.	Full - Member input is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 8) • QAC minutes – contains decision to leverage the existing Community Council to meet KAR requirements for a QMAC (Quality Member Access Committee) which is also open to community	Full	Addressed in the 2014 Q Program Description, on pages 8 and 15, and the 2013 QMAC Charter. Per the Charter, the committee meets at least once annually. Evidenced in the 2014 QI Work Plan, page 47, and in the QMAC meeting minutes, which contain discussion of and input from members about PIPs, access to providers, the Member Handbook, and community outreach/events. **Recommendation for Humana** Humana-CareSource should consider	

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**
	representatives and advocates for the members.		holding QMAC meetings quarterly or at least 3 times per year so that the committee can accomplish its diverse responsibilities.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - Addressed by: • Humana – - CareSource Quality Member Access Committee Charter 2013 • QMAC minutes	Full	Addressed in the 2014 QI Program Description, pages 8 and 15, and the 2013 QMAC Charter. Evidenced in the 2014 QMAC minutes. Note that the QAC reviews the QMAC activities and meeting minutes.	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	NA - Humana CareSource is not currently accredited. Accreditation is expected in 2016.	Full	Humana CareSource is scheduled for NCQA Accreditation Survey in July of 2016. Survey preparation is documented in the 2014 QI Work Plan.	
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.	NA - Humana CareSource is not currently accredited. Accreditation is expected in 2016.	Not Applicable	Humana CareSource is scheduled for NCQA Accreditation Survey in July of 2016.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review.	Substantial - Related language regarding annual	Full	Addressed in the 2014 QI Program Description and the 2014 QI Work Plan.	

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**
	update of the QI program is found in: Humana Kentucky Market Addendum Corporate Quality Improvement Program Description; p. 12 – the EDQMC (Humana East Division Quality Management Committee) reviews and updates Market Quality Improvement Program Descriptions as indicated and p. 22 – the corporate QIPD is reviewed and updated annually. Humana CareSource Work Plan – the QAPI PD is approved annually in March Language regarding annual submission of the QIPD to the Department is not found. **<u>Recommendation for Humana CareSource</u>** The Work Plan should include annual submission of the QIPD to the Department.		Humana included tasks in the QI Work Plan for submission of the required documents (e.g., QI Program Description) to DMS. The completed 2013 QI Work Plan was appended to Report #85. The 2014 QI Work Plan was submitted quarterly as Report #17. Evidenced in the 2014 QI Work Plan. The 2013 QI Program Description, 2014 QI Annual Evaluation and the completed 2013 QI Work Plan were submitted to DMS on July 24, 2014 with the Q3 2014 Report #85. The 2014 QI Program Description was submitted in Report #84. The 2014 QI Work Plan was submitted as Report #17, each quarter in 2014 and in Q1 2015.	

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**
	MCO Response: Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by the submission of Report 84 on or before July 31, 2014. Final Review Determination: No change in compliance level. Humana-CareSource submitted the QI Program Description timely in 2014 as described, however, the period of review was CY 2013. Additionally, Humana-CareSource should include the submission of the QI Program Description to DMS by July 31st annually in its QI Work Plan as stated in the original findings and recommendation.			
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and	Minimal – Integration of BH with medical health and the QI program is described	Full	Addressed in the 2014 QI Program Description, 2014 QI Work Plan and 2013 QI 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**
improving the quality and appropriateness of Behavioral Health Services provided to Members.	briefly in the QI Program Descriptions. The reader is referred to the partner/delegate Beacon program descriptions: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 7) • 2013 Quality Improvement Program, Humana CareSource (p. 18) The following Beacon documents address monitoring, evaluation and quality improvement: • Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 17-21) • 2013 HCS QAPI Work Plan – Delegate Beacon (Behavioral Health) Work Plan However, BH services evaluation is not further		The 2014 QI Program Description references BH quality improvement in the Goals on pages 6-7; QI Performance Monitoring and Evaluation Process on pages 7-8; Staffing and Resources on pages 16-18; and in Behavioral Healthcare Aspects of the QI Program on pages 19-21. Evidenced in the 2014 QI Work Plan, which contains updates on BH initiatives, including HEDIS measures related to BH; oversight of Care Management (CM), Utilization Management (UM), and call center functions; pharmacy/drug utilization monitoring for BH meds; PIPs on BH topics (Use of Antipsychotics in Children and Adolescents, Antidepressant Medication); participation in Medical Advisement meetings (member case reviews) as needed; weekly meetings with Beacon related to DCBS client cases; and the BH adult and child satisfaction survey fielded in Q3 2014. Evidenced in the 2013 QI Program Annual Evaluation which discusses continuity and coordination between behavioral and physical health care, member satisfaction with BH care and the PIPs related to BH topics.	

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**
	addressed in Humana CareSource documents, such as the Annual Program Evaluation (with the exception of the BH PIP).The 2014 Beacon Program Evaluation is not available for review; it is scheduled for committee review in July 2014. Evaluation of BH services was discussed during the onsite review. The MCO's subcontractor, Beacon, has a different schedule than the Contractor for completing/approving the annual program evaluation. Since this information would not be available to Humana CareSource when preparing the MCO's annual program evaluation, the MCO intends to use information obtained over the course of the year from Beacon in completing its evaluation. The QAC minutes include review and discussion of Beacon		Humana-CareSource also submitted the Beacon Health Services 2014 Quality Management and Improvement Program Description and 2013 Quality Management and Improvement Annual Evaluation. These documents did not specifically address Kentucky Medicaid or Humana-CareSource. **Recommendation for Humana** Beacon Health Services should include an addendum to its Quality Management and Improvement Program Description and Annual QI Evaluation that specifically addresses Kentucky Medicaid and the Humana MCO.	

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**
	metrics on a regular basis. **Recommendation for Humana CareSource** Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services. **MCO Response:** Humana – CareSource agrees with the recommendation and will incorporate behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program 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**
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.	Minimal – As above. Evaluation of physical health outcomes resulting from behavioral health integration are addressed only by: Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 19 – diabetes monitoring, cardiovascular monitoring, functional assessment, quality of life). **Recommendation for Humana CareSource** Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services. **MCO Response:** Humana – CareSource agrees with the recommendation and will incorporate behavioral	Full	As described in the prior element, Humana addressed behavioral health (BH) and physical health (PH) integration in its 2014 QI Program Description, QI Work Plan and 2014 QI Evaluation. Humana updated its 2014 QI Program Description to more fully address BH in Q4 2014, included the BH activities in its 2014 QI Work Plan and updates, and reported on its BH/PH activities in the 2014 QI Evaluation, including HEDIS measures for people with schizophrenia and diabetes, PIPs, and continuity and coordination of BH and PH care.	

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**
	health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program Evaluation.			
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 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	Full – As noted, the annual QAPI review (including policies, guidelines, utilization and outcomes) is described throughout: 2013 Quality Improvement Program, Humana CareSource (p. 21, 37 – submission to the state) and 2013 HCS QAPI Work Plan – will be submitted to KMS August 2014. The written evaluation report (including current activities and successes,	Full	Includes review of MCO Report #85 QI Plan & Evaluation Addressed in Report #85 2014 QI Program Description on pages 23-31, and the 2014 HCS QAPI Work Plan on page 1. Evidenced in Report #85 2014 QI Evaluation, which describes measurement, and evaluation, and analysis of each of the QI activities related to preventive services, care for chronic conditions, BH services and all other aspects of the clinical and non-clinical services provided to members, 2014 interventions, and planned 2015 interventions.	

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**
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.	planned trending and potential modification) is addressed by: Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013		Since 2014 was Humana-CareSource's first reporting year for HEDIS, CAHPS, the HK Performance Measures and other metrics, it was not possible to evaluate annual trends. Where applicable and feasible, the MCO reported quarterly trends. It is also important to note that the MCO served only Region 3 during measurement year 2013 and has since expanded statewide. Therefore, the RY 2015 data (MY 2014) will serve as the (new) baseline. Key findings in the QI Evaluation included: The MCO could not report many of the HEDIS measures due to lack of an eligible population and/or a denominator < 30. Of the measures HEDIS reported: The following HEDIS measures benchmarked at or above the 50th percentile: ADV, CDC – HbA1c testing and HbA1c Poor Control. The following preventive care measures benchmarked below the 50th percentile: Well-Care Visits for adolescents and children ages 3-6; Children's and Adolescents' Access to PCPs, ages 12 to 24 months and 25 months to 6 years; Lead	

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
			Screening in Children; Weight Assessment and Counseling for Children and Adolescents – Counseling for Nutrition and Physical Activity; for CSHCNs: Well-Care Visits, Annual Dental Visits, and Access to PCPs; Timeliness of Prenatal Care, Frequency of Prenatal Care, and Postpartum Care; and Adults Access to Preventive/Ambulatory Health Services. The following BH measures benchmarked below the 50th percentile: Diabetes Screening for People with Schizophrenia or Bipolar Disease Who Are Using Antipsychotic Medications; Follow-Up after Hospitalization for Mental Illness: 7 days and 30 days. The following acute and chronic care measures benchmarked below the 50th percentile: Appropriate Treatment for Children with URI; Pharmacotherapy Management of COPD Exacerbation; Controlling High Blood Pressure; LDL-C Screening; and 6 of 8 numerators for the Comprehensive Diabetes Care measure. The HK Performance Measure results were as follows: Adolescent Risk Screening/Counseling	

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
			rates ranged from < 22% for alcohol/substances to ~38% for tobacco. Tobacco screening for pregnant women was 8.5% and intervention for positive tobacco-use was 36.4%. Adult CAHPS results > 50th percentile: Rating of Health Plan; Rating of Health Care; Rating of Personal Doctor; Rating of Specialist. Adult CAHPS results < 50th percentile: Getting Needed Care; Customer Service; Getting Care Quickly; How Well Doctors Communicate; Shared Decision Making; and Health Promotion and Education. It is important to note that the CAHPS results are based on a total of < 400 responses. Provider satisfaction survey results included: > 60% overall satisfaction which ranked #2 among 4 Kentucky Medicaid MCOs; < 30% satisfaction for financial issues, utilization and quality, coordination of care/network, pharmacy, call center service and provider relations. Member and Provider Call Center results for abandonment rate exceeded goals (0.24% and 0.15%, respectively).	

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**
			The 2013 QI Evaluation, completed 2013 QI Work Plan and the 2013 QI Program Description were submitted to DMS in Report #85 in July 2014. The 2014 documents will be submitted in July 2015, as required. **Recommendation for Humana** For the 2015 QI Annual Evaluation, Humana-CareSource should include key accomplishments and priorities for the coming year in its annual evaluation summary.	
21.3 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 - As noted by pre-onsite document review, and onsite file review, information has been made available to the EQRO. Program descriptions generally address federal, state and accreditation entities; and site visits, examinations, inquiries or investigations. • 2013 Quality Improvement Program,	Full	Addressed in the 2014 QI Program Description, pages 35 and 37-38, and in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Humana has fully cooperated with submission of data, documents and records needed for EQR activities, including the compliance review, PIPs, performance measure validation, encounter data validation, surveys, and other optional EQR tasks.	

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**
	Humana CareSource (p. 20, 35). "All quality improvement activities are made available to Federal (CMS), State and Accreditation entities if requested." • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p, 18) "Section X. Compliance with Regulations. Humana maintains compliance with federal, state, and local regulatory bodies involved in the oversight of Managed Care Organization." "Activities may include: Participating in, and/or cooperating with site visits, examinations, inquiries, or investigations." Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.			

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**
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the 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 - Cooperation/participation in this EQRO review is noted. Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in the 2014 QI Program Description, pages 35 and 37-38, and in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Humana has fully cooperated with submission of data, documents and records needed for EQR activities, including the compliance review, PIPs, performance measures, encounter data validation, surveys, and other optional EQR tasks. DMS allows the use of accreditation survey findings to deem applicable requirements, where possible.	
21.4 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 P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in the 2014 QI Program Description, pages 35 and 37-38, and in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Humana-CareSource has fully cooperated with submission of data, documents and records needed for EQR activities, including the compliance review.	
The Contractor shall assist the Department and the EQRO	Full - Addressed in P/P QI-	Full	Addressed in the 2014 QI Program	

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**
in 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.	16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.		Description, pages 35 and 37-38, and in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Humana has fully cooperated with submission of data, documents and records needed for EQR activities, including performance measures, encounter data validation, surveys, and other optional EQR tasks.	
21.5 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 Contractor shall:	Full - Humana CareSource began operations in Kentucky in 2013 with the first EQRO review occurring in 2014. Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in Humana's responses to the 2014 compliance review findings and development and implementation of a corrective action plan (CAP) as directed by and approved by DMS.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - Addressed in P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in Humana's responses to the 2014 compliance review findings and development and implementation of a	

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**
			corrective action plan (CAP) as directed by and approved by DMS.	
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; and	Full - Addressed in P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Per Care Source P/P QI-16, Humana CareSource's Quality Assurance Committee serves this role.	Substantial	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in the QAC meeting minutes dated 12/2014. However, only the changes/additions to the QI Work Plan were discussed, the overall findings were not reviewed, nor was there evidence of committee involvement in the development, implementation and monitoring of the corrective actions. **Recommendation for Humana** Humana should present the overall findings for the annual compliance reviews (e.g., Executive Summary information - areas reviewed, overall score, highlights of elements needing corrective action, positive findings) to the QAC for information, input and monitoring of corrective actions. **Final Review Determination** No change in review determination. Humana should proceed with the plan to	Humana-CareSource agrees with the recommendation. However, given that the final findings of the 2013 DMS/IPRO annual review were not available until September of 2014, review of these items were only for the 4th Qtr, December 8 2014, meeting of the Quality Assessment Committee. This was not enough time to involve the committee in the development, implementation and monitoring of the corrective action plan. Humana-CareSource will present the overall findings for the 2014 annual compliance reviews to the QAC for information, input and monitoring of corrective actions. The discussion of findings will begin at the 2nd qtr QAC, 6/8/15.

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**
			present the 2014 compliance findings to the committee in Q2 2015 for discussion and input. Upon the next review, IPRO will evaluate the committee meeting minutes to ensure same.	
C. Submit a corrective action plan in 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.	Full - Addressed in P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in Humana's CAP submission to and approval by DMS.	
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 progressive and measurable improvement during the term of this contract; and	Full - Addressed in P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in Humana-CareSource's implementation of the approved CAP for the 2014 compliance assessment.	
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 - Addressed in P/P QI-16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	Full	Addressed in Policy and Procedure QI- 16 Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Evidenced in Humana's submission of responses to preliminary findings for the 2014 compliance review.	

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**
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full - CareSource prepares the Work Plan / Humana approves the Work Plan. Content and process are described in the following documents. • 2013 Quality Improvement Program, Humana CareSource (p. 21, 35, 37) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (20, 22) The 2013 HCS QAPI Work Plan was submitted for review. The Work Plan includes the Beacon (Behavioral Health) work plan.	Full	Includes review of MCO Report #17 QAPI Work Plan Addressed in the 2014 QI Program Description on page 37. Evidenced in Report #17 2014 QI Work Plan and updates submitted to DMS quarterly.	
outlines the scope of activities and	Full - The scope of activities is included in the 2013 HCS QAPI Work Plan.	Full	Addressed in the 2014 QI Program Description, page 37. Evidenced in the 2014 QI Work Plan updates submitted to DMS quarterly, in	

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
			Report #17. The 2014 QI Work Plan includes the scope, goals, timelines, responsible person/department, target completion date, issues identified, actions taken and analysis as well as an appended HEDIS-Performance Measure-specific work plan. The QI Work Plan also contains a column "Reported to CareSource QEC" though this column was not completed. **Recommendation for Humana** Humana should consider completing the column for reporting to the QEC, to identify when activities are reported to the committee. The MCO should also consider adding notations regarding reporting to other relevant committees (e.g., QAC, QMAC).	
the goals,	Full - Goals are included in the 2013 HCS QAPI Work Plan. Although not yet reported, the HEDIS section notes "Please reference corporate HEDIS Work Plan-KY Section," which was not found.	Full	Per above.	

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**
objectives, and	Full - Objectives are included in the 2013 HCS QAPI Work Plan.	Full	Per above.	
timelines for the QAPI program.	Full - Timelines are included in the 2013 HCS QAPI Work Plan.	Full	Per above.	
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.	Full - Required sources / findings and quarterly work plan updates are included in the 2013 HCS QAPI Work Plan.	Full	Addressed in the 2014 QI Program Description on page 37. Evidenced in the 2013 and 2014 QI Work Plans. Note that many measures could not be reported in 2013, the first year of MCO operation and a baseline rate was reported in 2014 for Region 3 only. Humana-CareSource is looking to RY 2015 to establish baseline rates for the statewide service area.	
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 program and annual QAPI work plan;	Full - Per the following documents, accountability is as follows: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (6, 9-12) • 2013 Quality	Full	Addressed in the 2014 QI Program Description, which states that the following are accountable for the QI program: the Humana BOD, the CEO and Corporate Medical Director, and the CQIC. The CQIC reports to the BOD which is chaired by the Corporate Medical Director. The BOD is responsible for annual review and approval of the QAPI Program	

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
	Improvement Program, Humana CareSource (p. 11) 1. The Market President (and CS QEC, HCS QAC) is responsible for the oversight / implementation of the quality improvement program at the local market level. 2. The East Division Director (and EDQMC) is responsible for oversight / approval of market quality improvement programs and work plans. 3. The Humana CQIC is ultimately responsible for approval of the overall QAPI program and work plan.		Description, QAPI Program Evaluation, and QAPI Work Plan. Evidenced in the 2014 QI Work Plan, which includes approvals of the QI Program Description, QI Work Plan and QI Annual Evaluation and the QAC meeting minutes.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - As above.	Full	Per above.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The CS QEC submits quarterly reports to the ED QMC; the ED QMC submits quarterly reports to the CQIC.	Full	Addressed in the 2014 QI Program Description. The QAC reports quarterly to the Humana Quality Improvement Committee, as well as to the QEC.	

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**
	• Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6) • 2013 Quality Improvement Program, Humana CareSource (p. 11)		Evidence of review and approval of QI documents and ongoing review of QI activities is demonstrated in the QAC meeting minutes.	
review on an annual basis of the QAPI program; and	Full - The HCS QAC and CQIC review the quality improvement program at least annually: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6) • 2013 Quality Improvement Program, Humana CareSource (p. 11, 21)	Full	Addressed in the 2014 QI Program Description Review and approval of the QI Program Description, QI Work Plan and QI Annual Evaluation is demonstrated in the QI Work Plan and QAC meeting minutes.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - As noted, reporting / review / follow-up and action plan development at all levels occurs at least quarterly. The work plan is updated quarterly. 2013 Quality Improvement Program, Humana	Full	Addressed in the 2014 QI Program Description on page 6, which states that the overarching goal of the Humana Quality Assessment/Performance Improvement (QAPI) program is a dynamic process to continually assess, analyze, and improve the quality of the care and services in order to continuously respond	

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**
	CareSource (p. 20-21).		to members' needs; and on page 7 which describes the core components of the QAPI process, monitoring system-wide issues; identifying opportunities for improvement; determining the root cause; exploring alternatives and developing a plan of action; activating the plan, measuring the results, evaluating effectiveness of actions and modifying the approach as needed. Evidenced in the 2014 QI Work Plan and quarterly updates and the 2013 and 2014 QI Evaluations.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full - As above. The Humana CareSource arrangement has resulted in multiple quality improvement committees: CS QEC, HCS QAC, ED QMC, CQIC.	Full	Addressed in the 2014 QI Program Description. As described previously, the committees include the Humana CQIC and executive QMC, the CareSource QEC and QAC and the related subcommittees. Note that in 2014, the MCO had a separate Clinical Advisory Committee; however, the committee minutes indicated that the CAC would be discontinued and instead, provider members would be added to the QAC in compliance with the Contract requirements. Evidenced in committee meeting minutes	

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**
			and the 2014 QI Work Plan.	
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 - Interdisciplinary committee membership addressed by: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 11 – ED QMC multispecialty) • 2013 Quality Improvement Program, Humana CareSource (p. 11 – CS QEC cross-functional with subject matter experts) • 2013 Charter Humana CareSource Quality Assessment Committee • HCS QAC minutes QAC includes 3 community practitioners – currently from family practice and pediatrics. The MCO is considering expansion to include specialty providers, dental, pharmacy, other provider types. QMAC includes Commission for	Full	Addressed in the 2014 QI Program Description on pages 10-12 and in the committee charters which describe interdisciplinary membership. The QEC is comprised of the Senior Vice President, Health Services; Vice President, Pharmacy; Vice President, Health Services; Director, Quality Improvement; and a cross- functional team of CareSource Executive, Senior, Operational Managers and Subject Matter Experts. The QAC is comprised of senior managers and managers from across the organization, Medical Director, QI, Health Services, Accreditation, Regulatory Compliance, Provider Relations, BH, Medical Management, Pharmacy, participating providers and Humana corporate representation. Evidenced in committee meeting minutes which demonstrate members in attendance.	

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**
	Children and other specialty providers as well as member representatives. QMAC reports to the QAC.			
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 - Addressed for the various quality committees as follows: Humana Kentucky Market Addendum Corporate Quality Improvement Program Description; CQIC meets monthly (p. 6); ED QMC reports quarterly (p. 12). 2013 Quality Improvement Program, Humana CareSource; CS QEC meets quarterly and maintains minutes (p. 11). 2013 Charter Humana CareSource Quality Assessment Committee; HCS QAC meets quarterly and maintains minutes, which were provided for this review.	Full	Addressed in the 2014 QI Program Description and QAC Committee Charter. The ED QMC meets monthly, the QEC meets quarterly or more often, and the QAC meets quarterly or more often. Evidenced in the QAC meeting minutes which demonstrate that the committee met quarterly in 2014, as required. **Recommendation for Humana** Humana should consider holding QAC meetings monthly or bi-monthly in order to fully address the wide range of committee responsibilities.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be	Full - 2013 HCS QAPI Work plan includes Beacon and	Full	Addressed in the 2014 QI Program Description, for Beacon BH on page 19 and	

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**
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.	MCNA as delegated entities. The Beacon, MCNA, and provider contracts were provided for review. All requirements were addressed by: • Master Services Agreement by and between CareSource Management Group Co. and Beacon Health Strategies LLC • Master Services Agreement by and between CareSource Management Group Co. and Managed Care of North America dba MCNA Dental Plans • ChoiceCare Network Participation Agreements amendment for providers participation with Kentucky Medicaid HMO network • Humana Network Participation Agreements amendment for providers participation with Kentucky Medicaid HMO		for providers on pages 21 and 32. Provider participation in QI activities is addressed in the Provider Manual under Credentialing/Recredentialing, Quality Performance Measures, and QI Program Goals. Contracts for Beacon and MCNA were reviewed. Participation in QI is addressed in Beacon contract under Exhibit A Scope of Services, DMS regulatory reporting and Exhibit D Delegation Services Attachment. Quality is not delegated to the dental vendor, MCNA; therefore, dental quality initiatives are based within the MCO. Addressed in the Provider Agreement in sections 7.4 and 8.1 and in the Letter of Agreement, HMO Provisions and Medicaid Required Provisions. Integration of QI activities is evidenced in the 2014 QI Work Plan and the 2014 QI 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**
	product			
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 - A multidisciplinary program integrating all business units is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 7, 11-15) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6, 16) • HCS QAC minutes	Full	Addressed in the 2014 QI Program Description in the Goals, QI Performance Measurement and Evaluation Process, Governing Body and Committee for Development, Implementation and Oversight of the QAPI Program, and Quality Improvement Activities as well as in the committee descriptions and in the Committee Charters. Evidenced in the committee meeting minutes/attendees and 2014 QI Work Plan and updates.	

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, 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.	Substantial - Resources, staffing and qualifications are addressed by:
	• 2013 Quality Improvement Program, Humana CareSource
	  o Executive and director-level staff (p. 15-17)
	  o Enterprise-wide staff participation (p. 21)
	• Humana Kentucky Market Addendum Corporate Quality
		Full	Addressed in the 2014 QI Program Description, which outlines the resources, staffing and qualifications including data and analytical resources on pages 15-19. And includes a statement that written documentation listing staffing resources, total FTE's, percentage of time, experience, and roles will be submitted to DMS upon request.
			
			Evidenced in the 2014 QI Work Plan and committee meeting minutes.	

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**
	Improvement Program Description o Quality Operations Compliance and Accreditation Department o Additional individuals from listed departments (p. 16-17) The Program Description does not include language regarding submission of information (FTE's and percentage of time dedicated to QAPI) to the Department upon request. Required activities are addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 8-9, 34-35) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 20-21)			

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
	Recommendation for Humana CareSource The Program Description should include reporting of staffing resources to the Department upon request. **MCO Response:** Humana - CareSource agrees with the recommendation and will include the language regarding submission of information (FTE's, and percentage of time dedicated to QAPI) to KDMS upon request into the 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee.			
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	New Requirement	Full	Addressed in the 2014 QI Work Plan. Evidenced in Report #17 2014 QI Work Plan and updates submitted quarterly to DMS.	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall	Minimal - All healthcare	Full	Includes review of MCO Report #23	

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**
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.	need indicators, evaluation and uses are described throughout the program descriptions and are presented in the program evaluation : • 2013 Quality Improvement Program, Humana CareSource (p. 17, 34 – validity) • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013 As noted in 19.1, HCS began serving members in January of 2013 and the ability to measure the overall effectiveness of the QI Program lags. Empty table shells for 2013 and 2014 measurement were provided, as were barriers based on experience, activities and plans. Also noted in 19.1, information regarding Behavioral Health		Evidence Based Guidelines for Practitioners Addressed in the 2014 QI Program Description which describes the process to monitor and evaluate and improve the quality of care and services under Goals, QI Performance Monitoring and Evaluation Process, BH Aspects of the QI Program, Quality Assurance and Improvement Plans, QI Activities, Overall Effectiveness and Demonstrated Improvement, Ongoing Analysis of Key Performance Measures, Quality Assessment Performance Improvement Program and the descriptions of the specific activities. Humana added a description of BH QI activities to the 2014 QI Program Description and addressed BH QI in the 2014 QI Evaluation. Evidenced in the 2104 QI Work Plan and updates, committee meeting minutes, and the 2014 QI Evaluation as well as in routine reporting, such as HEDIS, delegation oversight, CAHPS, HK Performance Measures, PIPs and quarterly regulatory reports, including Report #23 Evidence Based Guidelines for	

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**
	monitoring, evaluation and improvement are provided by: • Beacon Health Strategies 2013 Quality Management and Improvement Program Description • 2013 HCS QAPI Work Plan – Delegate Beacon (Behavioral Health) work plan BH services evaluation was not addressed in the Humana CareSource Program Evaluation as noted above. **Recommendation for Humana CareSource** Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services.		Practitioners. For additional information on evidenced based guidelines, see 19.4 E.	

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**
	MCO Response: Humana - CareSource agrees with the recommendation and will incorporate behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program Evaluation.			
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - Monitoring adherence to practice guidelines is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 17, 30-31) • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 3) • 2013 Performance	Full	Addressed in the 2014 QI Program Description and Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy. Evidenced in the 2014 QI Work Plan and 2014 QI Evaluation; the report Altegra Health Medical Record Review-Adult Visits for Diabetes Care and Adolescent Well Child Visits; and in results of population-based measures such as HEDIS, HK Performance Measures.	

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**
	Measures Summary – medical record review to be conducted 3rd and 4th quarter 2014 Population-based and practice-based assessment is described, with HEDIS results where applicable. Several panned HEDIS measurements, based on guideline use, were presented in: • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013			
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - Escalating intervention is used: 2013 Quality Improvement Program, Humana CareSource (p. 30).	Full	Addressed in the 2014 QI Program Description under Quality Improvement Performance Monitoring and Evaluation Process. Evidenced in the 2014 QI Work Plan under Issues Identified, Actions Taken to Address Identified Issues and Assessment/Analysis as well as in the 2014 QI Evaluation in the presentation of results, barriers, 2014 Interventions and Planned 2015 Interventions.	

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**
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - As above. Medical record review is ongoing: 2013 Quality Improvement Program, Humana CareSource (p. 31).	Full	Per Above	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - Cross-functional teams are addressed throughout, but specifically by: • 2013 Quality Improvement Program, Humana CareSource (p. 21, 37) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 11 – ED QMC) • HCS QAC minutes	Full	Addressed in the 2014 QI Program Description, under Committees for development, implementation; and oversight of the QAPI Program as well as in the 2014 QAC Charter. Evidenced in the committee meeting minutes and in the 2014 QI Work Plan, Responsible Person.	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.	Full - Submission to the state of all projects is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35) • Humana Kentucky Market Addendum Corporate Quality Improvement Program	Full	Addressed in the 2014 QI Program Description under QI Performance Monitoring and Evaluation Process. Evidenced in the 2014 QI Work Plan, Performance Improvement Projects and QI Activities, pages 39-42 and in Reports #90 and #92 submitted to DMS annually and Report #19 submitted to DMS quarterly.	

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**
	Description (p. 18)			
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full - Guideline dissemination is addressed by: Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2).	Full	Addressed in the 2014 QI Program Description, QI Performance Monitoring and Evaluation Process and in Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care. The CareSource corporate office sets, reviews and updates clinical practice guidelines. New or revised guidelines are communicated to the Kentucky market and changes are made accordingly. Evidenced in Report #23 submitted to DMS quarterly, 2014 QI Work Plan on pages 25-26. Evidence of dissemination to providers is found in the Provider Manual, Preventive Guidelines and Clinical Practice Guidelines on page 73 and throughout the manual, as well as via Provider Newsletters and MCO website posting. Evidence of dissemination to members is found in the Member Handbook, Preventive Guidelines on page 37.	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full - Guideline sources are addressed by: Quality	Full	Addressed in Policy and Procedure QI-03 Development and Distribution of	

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**
	Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2).		Preventive Health and Clinical Practice Guidelines for Care. Evidenced in Report #23 submitted to DMS quarterly, 2014 QI Work Plan on pages 25-26. A review of the guidelines posted on the MCO website shows the following sources for guidelines: American Academy of Child and Adolescent Psychiatry (AACAP), National Heart, Lung and Blood Institute (NHLBI), Agency for Healthcare Research and Quality (AHRQ), American Academy of Pediatrics (AAP), Centers for Disease Control (CDC), American Psychiatric Association (APA) and American Congress of Obstetricians and Gynecologists (ACOG).	
consider the needs of Members;	Full - Guideline topics are identified through analysis of enrolled membership: Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2).	Full	Addressed in 2014 QI Program Description, under Goals, QMAC description and in Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care. Evidenced in the 2014 QI Work Plan under Member Demographics; use of the Persona tool to identify member characteristics; and in the guidelines on the MCO website, which are posted by	

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**
			member type, e.g., Temporary Aid to Needy Families (TANF), Seriously Mentally Ill (SMI), Aged, Blind, Disabled (ABD).	
developed or adopted in consultation with contracting health professionals, and	Full - Inclusion of board-certified practitioners from appropriate specialties is addressed by: Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2).	Full	Addressed in Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care. Evidenced in the 2014 CAC meeting minutes.	
reviewed and updated periodically.	Full - Guidelines are reviewed and updated at least every two years: Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2).	Full	Addressed in Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care. The CareSource corporate office sets, reviews and updates clinical practice guidelines. New or revised guidelines are communicated to the Kentucky market and changes are made accordingly. Evidenced in the 2014 CAC meeting minutes as well as by the fact that the MCO website guidelines are accessed via links to the source websites ensuring the	

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**
			most recent guidelines are available.	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	Full - Consistency with guidelines is addressed by: Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 4). Monitoring consistent application of guidelines is addressed by: 2013 Performance Measures Summary – medical record review to be conducted 3rd and 4th quarter 2014.	Substantial	Addressed in Policy and Procedure QI-03 Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care. The CareSource corporate office sets, reviews and updates clinical practice guidelines. New or revised guidelines are communicated to the Kentucky market and changes are made accordingly. Evidence for evaluating consistency of UM and coverage decisions is seen in inter-rater reliability testing. Results were as follows: turnaround time was 100% compliant and quality monitoring scores ranged from 93% to 97%, meeting and exceeding goal. Humana QI staff described the process for development of member education materials consistent with guidelines. QI and Health Services (HS) are responsible for development of member education materials for the local Kentucky market. The process was described as follows: QI and HS teams review materials to ensure they are consistent with guidelines and up-to-date. The team is comprised of the Medical Director, Quality Manager,	Humana-CareSource agrees with this recommendation and will develop a Policy and Procedure to address the process for development of member education material consistent with guidelines and include a step for review of materials by the QMAC to ensure member input on understanding and visual appeal of the materials.

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
			Director of Health Services and Provider Relations. Where applicable, subject matter experts such as dental, vision, behavioral health will review the materials. Materials are then reviewed by the Communications Department for formatting and reading level. The completed version is reviewed and approved by Humana committee and then sent to DMS for final approval. Evidence of assessment of provider practice consistent with guidelines is seen in the Altegra/Outcome Assessment of Visits for Diabetes and Adolescent Well Care Visits as well as via results for HEDIS measures and HK Performance Measures. **Recommendation for Humana** Humana should document the process for development of member education material consistent with guidelines in a Policy and Procedure. The MCO should ensure that the Policy and Procedure includes a step for review of materials by the QMAC to ensure member input on understanding and visual appeal of the materials.	

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
			Final Review Determination No change in review determination. Humana should proceed with the plan to develop a Policy and Procedure, including review of materials by the QMAC. Once approved, it should be submitted to DMS and implemented. Upon the next review, IPRO will evaluate the Policy and QMAC meeting minutes to ensure same.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	Full - Innovative program implementation (and reporting) addressed by: Innovative Program Description and Status Update – Babies First Program Humana CareSource provided documents and reports related to the Medication Therapy Management (MTM) program. The MTM program is a collaborative	Full	Humana innovative programs include the Babies First Program, Medication Therapy Management (MTM), Dental Program for SMI, and Clinical Practice Registry (CPR). **Babies First Program** The Babies First Program was developed to encourage mothers to seek prenatal, postpartum and well-baby care and promote the health of pregnant and post-partum members and their babies by using incentives. This program began in July 2013 for Kentucky members. In 2014, a total of 3,762 incentives were distributed. During 2014 a conversion from the	.

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
	project that includes Humana CareSource; its subcontractor, Outcomes MTM; and community pharmacists. The program includes an annual Complete Medication Review that allows members to meet one-on-one with a pharmacist to review their complete medication profile to detect and prevent conflicts or duplications. iConnect is another innovative program implemented by Humana CareSource that allows members to communicate ideas and provide feedback to the MCO on its programs and services. Members choose their method of communication – text, email, or social media. Approximately 130 members have joined iConnect.		coupon-based program to a more efficient claims-based MyCareSource Rewards debit card system in hopes of increasing participation. This will also allow the MCO to limit and restrict purchases which are prohibited, such as alcohol and tobacco. **Medication Therapy Management** The Medication Therapy Management (MTM) Program was implemented in 2013 with a goal of improving health outcomes by reducing medication interactions, inappropriate medications, duplicate medications and overutilization. Pharmacists work with prescribers and members to enhance quality of care, improve medication compliance, address medication needs, and improve cost-effectiveness. **Dental Program for Seriously Mentally Ill** The Dental Program for Individuals with serious mental illnesses (SMI), children and youth with serious emotional disorders (SED) and those affected by alcohol and other drug addictions provides medical, behavioral, and dental care coordination. The program's goals are to increase awareness of dental problems and develop referral mechanisms that increase access to ongoing dental care for	

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**
			these members. **Clinical Practice Registry** The Clinical Practice Registry (CPR) is an on-line tool accessible via the Provider Portal. The primary purpose of the CPR is to help providers manage their patient populations by providing direct access to the Member Profile containing claims history such as diagnoses, pharmacy utilization data, ambulatory utilization, emergency department and inpatient utilization, and history of preventive health services. Panel members can be sorted into actionable groups and color-coding provides easy identification of members in need of a test or screening.	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix N, 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	Full - KY-specific performance measures addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 21-28) • 2013 Performance Measures Summary – Healthy Kentuckians Outcomes Measure	Substantial	Addressed in the 2014 QI Program Description on pages 8 and 24-30 (HK Performance Measures) and pages 7-8, 13, 34-35 and 37 (HEDIS). Evidenced in the 2014 QI Work Plan; however, these performance measures were reported for the first time in July 2014 and there was no Q4 2014 update on analysis or improvement activities.	Humana-CareSource agrees with this recommendation and will ensure that analysis of results and interventions for the HK Performance Measures are included in the 2015 QI Work Plan and the quarterly updates.

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**
measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Report currently being compiled for 2013		Also, the Measure-specific Work Plan does not address the HK Performance Measures specifically. However, the State performance measures are included in the 2014 QI Evaluation. It is important to note that the MCO served only Region 3 during measurement year 2013 and has since expanded statewide. Therefore, the 2015 data will serve as the (new) baseline rates. **Recommendation for Humana** Humana should ensure that analysis of results and interventions for the HK Performance Measures are included in the 2015 QI Work Plan and the quarterly updates. **Final Review Determination** No change in review determination. Humana should proceed with the plan to include analysis of results and interventions for the HK Performance Measures in the QI Work Plan and the quarterly updates. Upon the next review, IPRO will evaluate the QI Work Plan to ensure same.	

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**
Additionally, the Department, Contractor, and 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.	Full - KY-specific performance measures addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 21-28) • 2013 Performance Measures Summary – Healthy Kentuckians Outcomes Measure Report currently being compiled for 2013	Not Applicable	DMS has not elected to rotate any performance measures at this time. The 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.	Full - Primary care source, annual physical exam, and biannual dental exam for children with SHCN was addressed by: 2013 Quality Improvement Program, Humana CareSource (p. 27-28).	Not Applicable	DMS, IPRO and the previously participating MCO(s) developed a set of performance measures for ISCHN prior to Humana joining the Kentucky Medicaid program. Humana reported the CSHCN performance measures as evidenced in Attachment B – Performance Measure Reporting Template.	
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.	NA - HEDIS 2014 will be available June 2014 and will provide baseline data.	Not Applicable	Humana-CareSource reported HEDIS and the HK Performance Measures for the first time in 2014; therefore, improvement cannot be assessed.	
Specific quantitative performance targets and goals are	Substantial - The 2013 HCS	Full	DMS has not opted to set specific	

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**
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.	QAPI Work Plan contained quarterly updates. Planned stratification was not evident in these documents. **Recommendation for Humana CareSource** The QAPI Work Plan should include plans for stratification of performance data and analysis of this data. **MCO Response**: Humana-CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly updates to the work plan and the planned submission of Attachment A (state specific measures) due to IPRO on 9/5/14. Final Review Determination: No change in compliance level. Humana Care-Source was		performance targets at this time. The measure set is evaluated annually by DMS and the EQRO, IPRO. Humana sets targets based on the Quality Compass benchmarks for HEDIS and on statistically significant improvement. Addressed in the 2014 QI Work Plan on page 7 (HEDIS) and on page 8 (HK Performance Measures). The 2014 QI Work Plan includes a task for reporting stratified HEDIS and HK Performance Measure data. Evidenced in the 2014 QI Work Plan quarterly updates and in Report #96 submitted annually to DMS.	

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**
	compliant with the requirement to submit quarterly reports of performance measures to DMS. However, Humana-CareSource was not compliant with the requirement to stratify performance measure data by Medicaid eligibility category, race, ethnicity, gender and age. Although the MCO did not have performance measure data in 2013, plans to stratify the data, when available, should have been reflected in the QI Work Plan.			
20.2 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 organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.	Full - Submission of Final Auditor's Report is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35) • 2013 HCS Work Plan – HEDIS entry: HEDIS will be conducted in 2014. Please reference	Full	Includes review of MCO Report #96 Audited HEDIS Reports Addressed in the 2014 QI Program Description on pages 7-8, 13, 34-35 and 37 and in the 2014 QI Work Plan on pages 7-8 and 56-84. Evidenced in annual Report #96 HEDIS IDSS, Final Audit Report and stratified HEDIS data, submitted to DMS.	

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**
	corporate HEDIS Work Plan-KY Section (not seen). • 2013 Performance Measures Summary – by August 31 via Report 96			
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 - The 2013 HCS QI Program Evaluation was submitted with table templates due to reporting lags. Templates displayed year-to-year trending. In areas where measurement was possible (calls, grievances, appeals) numerators and denominators were often displayed.	Full	Addressed in the 2014 QI Program Description on pages 7-8, 13, 34-35 and 37 and in the 2014 QI Work Plan on pages 7-8 and 56-84. Evidenced in annual Report #96 HEDIS IDSS, Final Audit Report and stratified HEDIS data, submitted to DMS and in the 2014 QI Annual Evaluation. In the 2014 QI Evaluation, rates and benchmarks are presented; however, since this is the first reporting year, no trending is possible. It is important to note that the MCO served only Region 3 during measurement year 2013 and has since expanded statewide. Therefore, the 2015 data will serve as the (new) baseline.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category,	Substantial - The 2013 HCS QI Program Evaluation was submitted with table	Substantial	Addressed in the 2014 QI Program Description on pages 7-8, 13, 34-35 and 37 and in the 2014 QI Work Plan on pages 7-8	**DMS Response** This element received a substantial in 2014 and again in 2015. The plan did not follow the recommendations for 2014 and

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**
race, ethnicity, gender and age.	templates due to reporting lags. Planned stratification was not addressed in this document. **Recommendation for Humana CareSource** The QI Program Evaluation should include stratification of performance data and analysis of this data. **MCO Response:** Humana-CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly updates to the work plan and the planned submission of Report 96 due to KDMS on 8/31/14. Final Review Determination: No change in compliance level. Humana Care-Source was compliant with the requirement to submit quarterly reports of performance measures to		and 56-84. Evidenced in annual Report #96 HEDIS IDSS, Final Audit Report and stratified HEDIS data, submitted to DMS. The 2014 QI Evaluation reports the HEDIS rates, benchmarks, goals, and interventions but does not address the stratification and analysis of the data. **Recommendation for Humana** Humana should include results of the data stratification, analysis and planned actions in the QI Evaluation, where applicable. If there are no pertinent findings, Humana should include a statement that data were stratified but no opportunities were identified when the data were analyzed. **Final Review Determination** No change in review determination. Humana should proceed with the plan to incorporate the results of data stratification, analysis and planned actions or make a notation that there were no pertinent findings. Upon the next review, IPRO will evaluate	this action concerns DMS. Humana-CareSource agrees with this finding and will include results of the data stratification, analysis and planned actions in the QI eval where applicable. If there are no pertinent findings, Humana-CareSource will include a statement that data were stratified but no opportunities were identified when the data were analyzed.

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**
	DMS. However, Humana-CareSource was not compliant with the requirement to stratify HEDIS data by Medicaid eligibility category, race, ethnicity, gender and age. Although the MCO did not have performance measure data in 2013, plans to stratify the data, when available, should have been reflected in the QI Work Plan.		the QI Evaluation to ensure same.	
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.	NA - To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	Not Applicable	DMS has not opted to choose a subset of HEDIS measures for evaluation. The 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.	NA - To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	Not Applicable	DMS has not opted to choose a subset of measures for evaluation using MCO submitted encounter data. The measure set is evaluated annually by	

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**
			DMS and the EQRO, IPRO.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status 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.	NA - Humana is not currently NCQA accredited in Kentucky. NCQA accreditation of the Humana Medicaid program in Florida and the Humana CareSource plan is noted. Work toward becoming accredited in Kentucky is addressed by the 2013 Quality Improvement Program, Humana CareSource (p. 6).	Not Applicable	As noted previously, Humana-CareSource is preparing for its first accreditation survey, scheduled for July 2016.	
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.	Full - Required accreditation within 2 – 4 years is addressed by 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program (p. 18).	Not Applicable	Per Above.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas	Full - PIP topic	Full	Includes review of MCO Reports:	

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**
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.	considerations are addressed by: • 2013 HCS QI Program Evaluation (p. 24) • 2013 HCS QAPI Work Plan		#19 PIPs #90 PIP Proposal #92 PIP Measurement Addressed in the 2014 QI Program Description and the 2014 QI Work Plan. Evidenced in Report #19 PIPs (progress and status of performance improvement projects), Report #90 PIP Proposals, and Report #92 PIP Measurement. In CY 2014, the MCO submitted PIP proposals for Postpartum Care and Use of Antipsychotics for Children and Adolescents and baseline measurements for the ED Utilization PIP and the Major Depressive Disorder – Use of Antidepressants PIP.	
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	Full - PIPs may be developed around clinical and service issues requiring a coordinated and concerted effort for resolution. PIPs are included in the work plan and program evaluation: • 2013 Quality Improvement Program, Humana CareSource (p. 20, 35)	Full	Addressed in the 2014 QI Program Description and the 2014 QI Work Plan. Evidenced in Report #19 PIPs (progress and status of performance improvement projects), Report #90 PIP Proposals and #92 PIP Measurement and in the 2014 QI Work Plan. In CY 2014, the MCO submitted PIP proposals for Postpartum Care and Use of	

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**
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 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.	• 2013 HCS QAPI Work Plan (clinical PIPS noted) • 2013 HCS QI Program Evaluation (clinical PIPS and ongoing CAPHS QIP noted) General prohibitions on incentives to limit care are found in: • Humana CareSource Provider Manual (p. 81) • Beacon Humana CareSource Provider Manual (p. 19)		Antipsychotics for Children and Adolescents and baseline measurements for the ED Utilization PIP and the Major Depressive Disorder – Use of Antidepressants PIP. The project topics for both physical and behavioral health PIPs were directed and/or approved by DMS. The 2015 PIP topic, Use of Antipsychotics for Children and Adolescents is a Statewide collaborative directed by DMS. Evidence of planning and implementation of system interventions is found in the PIP reports. There is no evidence of payments to providers as an inducement related to the PIPs.	
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.	Full - Collaborative relationships with BH and community-based organizations is noted in: • 2013 HCS QI Program Evaluation (America n Diabetes Association (ADA), American Lung Association (ALA), National Alliance for the Mentally Ill (NAMI), Community Mental	Full	Evidenced in Report #19 PIPs (progress and status of performance improvement projects), Report #90 PIP Proposals and #92 PIP Measurement and in the 2014 QI Work Plan. For example, in the Use of Antipsychotics for Children and Adolescents PIP, the MCO is collaborating with DMS, the other Kentucky Medicaid MCOs and University of Louisville's pediatric research branch.	

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**
	Health Centers (CMHC)) • Humana - CareSource Quality Member Access Committee Charter 2013 and minutes • Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 3, 21 – state agencies)		Other collaborative relationships with government agencies and community agencies are seen in the QMAC meeting minutes and the 2014 QI Evaluation.	
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.	NA - As 2013 is the MCO's first year of operations, development of best practices and use of encounter-data driven performance measures is not applicable. Performance measure reporting is scheduled for June 2014. **Recommendation for Humana CareSource** Language regarding the development of best practices should be included in the 2014 Program Description. **MCO Response:** Humana-	Substantial	The 2014 QI Program Description addresses a commitment to collaboration and use of data-drive performance measures; however, it does not specifically reference a commitment to the development of best practices, except in relation to care management programs. As noted above, the MCO has developed on-going collaborative relationships in its service and clinical care improvement efforts. Humana has just reported its baseline measurements for two PIPs and proposals for two PIPs; therefore, the MCO has not had an opportunity to develop best practices. Sufficient data is not yet available to use	Humana-CareSource agrees with this recommendation and will include the commitment to development of best practices in its QI Program Description.

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**
	CareSource agree the Quality Improvement Program Purpose content, and Alignment with the CMS Quality Strategy language which addresses best practices and performance measures will be included in the KY QIPD MCD addendum with next version update.		for encounter data–driven performance measures. It is important to note that the MCO served only Region 3 during measurement year 2013 and has since expanded statewide. Therefore, the 2015 data will serve as the (new) baseline. **Recommendation for Humana** Humana should include the commitment to development of best practices in its QI Program Description. **Final Review Determination** No change in review determination. Humana should proceed with the plan to incorporate the suggested wording in the QI Program Description. Upon the next review, IPRO will evaluate the QI Program Description to ensure same.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its	Full - Humana CareSource will conduct annually, one medical and one behavioral health PIP: 2014 Kentucky Market Addendum,	Full	Addressed in the 2014 QI Program Description and the 2014 QI Work Plan. Evidenced in Report #19 PIPs (progress and status of performance improvement	

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**
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 may 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.	Corporate Quality Improvement Program Description, and Medicaid Managed Care Program (p. 20). Compliance with clinical studies and collection of indicator data as required by State, Federal or other regulatory agencies addressed by: 2013 Quality Improvement Program, Humana CareSource (p. 34). PIP report submission to the EQR and Department addressed by: 2013 HCS QAPI Work Plan and 2013 HCS QI Program Evaluation (p. 24-25).		projects), Report #90 PIP Proposals and #92 PIP Measurement and in the 2014 QI Work Plan. In CY 2014, the MCO submitted PIP proposals for Postpartum Care and Use of Antipsychotics for Children and Adolescents and baseline measurements for the ED Utilization PIP and the Major Depressive Disorder – Use of Antidepressants PIP. The project topics for both physical and behavioral health PIPs were directed and/or approved by DMS. The 2015 PIP topic, Use of Antipsychotics for Children and Adolescents is a Statewide collaborative directed by DMS.	
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix M. – Per Region 3 contract OR The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor	Full - Two PIP proposals were submitted : To reduce the incidence of major depression that is untreated with antidepressant medication therapy, and Emergency Department Use Management	Full	Addressed in the 2014 QI Program Description and the 2014 QI Work Plan. Evidenced in Report #19 PIPs (progress and status of performance improvement projects), Report #90 PIP Proposals and #92 PIP Measurement and in the 2014 QI Work Plan. The project topics for both physical and	

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**
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. – Per Other Regions contract			behavioral health PIPs were directed and/or approved by DMS. The 2015 PIP topic, Use of Antipsychotics for Children and Adolescents is a Statewide collaborative directed by DMS	
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 – As above.	Full	In 2014, Humana submitted PIP proposals and baseline PIP reports using the required template and the updated template, as applicable.	
A. Topic and its importance to enrolled members;	Full - Addressed in each PIP proposal.	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. As noted above, topic selection was approved for all PIPs. The PIP reports included a rationale for the selected topics supported by literature citations and data (national, Kentucky, MCO) as applicable.	
B. Methodology for topic selection;	Full - Addressed in each PIP proposal.	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. As described above, topic selection was approved for all PIPs. The PIP reports included a rationale for the selected topics supported by literature citations and data (national, Kentucky, MCO) as applicable.	

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**
C. Goals;	Full - Addressed in each PIP proposal. In addition to outcome goals, several process measurements and goals are included in each proposal.	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. Humana establishes goals for each PIP indicator, such as national benchmarks or standards for meaningful improvement and supports the goal selection with a logical rationale.	
D. Data sources/collection;	Full - Addressed in each PIP proposal. Barrier assessment / process measurement include several data sources.	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. Humana fully and clearly describes the data sources for all PIP indicators, for both standard measures (HEDIS) and MCO-developed measures.	
E. Intervention(s) – not required for projects to establish baseline; and	NA - Addressed in each PIP proposal. Interventions are to be developed beginning 1/1/14. Planned interventions extend through 12/31/15. Collaboration with Beacon is noted.	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. Evidenced in Humana's PIP proposals and baseline PIP reports. Although Humana has only submitted PIP proposals and baseline reports to date, the MCO has included barrier analyses and planned interventions for all PIPs.	
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.	NA - Baseline measurement 12/31/13, 1st re-measurement 12/31/14 and 2nd re-measurement	Full	Evidenced in Humana's PIP proposals and baseline PIP reports. Humana has reported its first baseline	

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**
	12/31/15.		measurements in 2014; therefore, results and interpretation related to improvement and goals is not yet possible.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	NA - Confidentiality is addressed in each PIP proposal. Final reports are not due.	Not Applicable	No final remeasurement reports are due; however, member confidentiality is addressed in each PIP proposal.	
B. Did Members participate in the performance improvement project;	NA - Members are engaged in each PIP proposal. Final reports are not due.	Not Applicable	No final remeasurement reports are due; however, member engagement and participation is addressed in each PIP proposal.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	NA - Final reports are not due. However, it is noted that ED use management proposal noted savings attributable to Triage Nurse Line during preliminary measurement Jan-June 2013.	Not Applicable	No final remeasurement reports are due; therefore, financial impact cannot be assessed or reported.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	NA - Final reports are not due.	Not Applicable	No final remeasurement reports are due; therefore, dissemination of results and conclusions to members, providers and others cannot be assessed.	
E. Is there an executive summary;	NA - Final reports are not due.	Not Applicable	No final remeasurement reports are due; therefore, it is not possible for Humana to	

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**
			provide an executive summary.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	NA - Final reports are not due.	Not Applicable	No final remeasurement reports are due; however, Humana reported baseline data for two PIPs clearly in tables and narrative and included the improvement goals.	
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	Full - Addressed by each PIP proposal: Baseline measurement serves as minimum performance level for each PIP proposal. Pre-determined goals are described as percentage improvement over baseline.	Full	Evidenced in Humana's proposals and baseline PIP reports. No remeasurement data is due at this time; however, the MCO has established appropriate indicators and goals as described below. Humana has used both standardized HEDIS indicators and related MCO-specific indicators for its PIPs. Additionally, the MCO has adapted HEDIS indicators when necessary to fit MCO circumstances (e.g., enrollment timeframes). Humana has used both national norms (Quality Compass percentile benchmarks) as well as MCO-established goals with appropriate rationale. Goals are set at the time of the PIP proposal submission and where appropriate, modified based on baseline where necessary.	
The Contractor shall validate if improvements were	Full - Addressed by 2013	Not Applicable	No final remeasurement reports are due;	

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**
sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	HCS QI Program Evaluation (p. 24-25).		therefore, sustained improvement cannot be evaluated.	
A. Project Proposal – due September 1 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.	Full - Proposal submitted to KDMS 3/27/13 and to IPRO and KDMS 12/8/13: 2013 HCS QAPI Work plan.	Full	Humana has submitted its PIP proposals timely in 2013 and 2014.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Full - Addressed by 2013 HCS QAPI Work plan.	Full	Humana has submitted baseline reports for two PIPs timely in 2014.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	Full - Addressed by 2013 HCS QAPI Work plan.	Not Applicable	No remeasurement data is due at this time.	
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	Full - Addressed by 2013 HCS QAPI Work plan.	Not Applicable	No final remeasurement data is due at this time.	
20.5 Quality and Member Access Committee				
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.	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Includes review of MCO Report #21 MCO Committee Activity Addressed in the 2014 QI Program Description, on page 15 and QMAC Charter. Members include MCO staff: Medical Director, Senior Managers and representatives from the BH, QI, Provider Relations, Health Services, and Community	

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
			Education departments, as well as Medicaid members and Community Advocates and Partners. Human notes in the committee charter that membership is fluid as QMAC is under development. Evidenced in the QMAC meeting minutes, in which attendees are listed. Regarding Report #21, the following were found in the quarterly reports submitted by Humana to DMS: Q1 2014 – Report #21 not found. Q2 2014 – Report #21 indicates that there was no QMAC meeting held in Q2 2014. Q3 2014 – Report #21 includes minutes for 2 QMAC meetings held in September 2014. Q4 2014 – Report #21 indicates that there was no QMAC meeting held in Q4 2014. Humana submitted QMAC meeting minutes for 3 meetings in 2014 with the pre-onsite documentation. These were reviewed. The meeting held in March 2014 was not included in the quarterly reports, as Report #21 for Q1 2014 was not found. Note that according to the QMAC Charter, meetings are to be held annually, at a minimum. Humana exceeded that	

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**
			requirement, with 3 meetings held in 2014. **Recommendation for Humana** Humana should ensure that Report #21 is submitted to DMS each quarter and that, when applicable, documentation of QMAC meetings is included.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. 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:	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Per above	
A. Providing review and comment on quality and access standards;	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Addressed in the 2014 QI Program Description and QMAC Charter. Evidenced in the 2014 QI Work Plan, page 47, and in the QMAC meeting minutes, which contain discussion of and input from members about PIPs, access to providers, the Member Handbook, and community outreach/events.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed	Full - Addressed by: Humana – CareSource Quality	Minimal	Addressed in the 2014 QI Program Description and QMAC Charter.	Humana-CareSource agrees with this recommendation. The grievance and appeal process and policy modifications needed

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**
based on review of aggregate Grievance and Appeals data;	Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.		Specific discussion of and input from members about the Grievance and Appeals process was not found in the QMAC meeting minutes. **Recommendation for Humana** Humana should ensure that the QMAC fulfills all its stated functions, including review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data. **Final Review Determination** No change in review determination. Humana should proceed with the plan to ensure that the QMAC fulfills its stated functions and this is documented in the committee meeting minutes. Upon the next review, IPRO will evaluate the March QMAC meeting minutes to ensure same for CY 2015.	based on reviewing aggregate grievance and appeal data were reviewed at the March 24 and 26, 2015 QMAC meetings. However, this review was not conducted in 2014. Going forward this review will be conducted along with other QMAC stated functions, annually.
C. Providing review and comment on Member Handbooks;	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS	Full	Addressed in the 2014 QI Program Description and QMAC Charter. Evidenced in the 2014 QI Work Plan, page	

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**
	QMAC /Consumer Council minutes.		47, and in the QMAC meeting minutes, which contain discussion of and input from members about PIPs, access to providers, the Member Handbook, and community outreach/events.	
D. Reviewing Member education materials prepared by the Contractor;	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Minimal	Addressed in the 2014 QI Program Description and QMAC Charter. Review of member education materials prepared by the Contractor, other than the Member Handbook, was not found in the QMAC meeting minutes. **Recommendation for Humana** Humana should ensure that the QMAC fulfills all its stated functions, including Reviewing Member education materials prepared by the MCO. **Final Review Determination** No change in review determination. Humana should ensure that the QMAC fulfills its stated functions and this is documented in the committee meeting minutes. Upon the next review, IPRO will evaluate the QMAC meeting minutes to ensure	

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**
			same for CY 2015.	
E. Recommending community outreach activities; and	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Addressed in the 2014 QI Program Description and QMAC Charter. Evidenced in the 2014 QI Work Plan, page 47, and in the QMAC meeting minutes, which contain discussion of and input from members about PIPs, access to providers, the Member Handbook, and community outreach/events.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Addressed in the 2014 QI Program Description and QMAC Charter. Evidenced in QMAC meeting minutes, including discussion of changes to coverage for substance abuse treatment and overall Medicaid benefit changes.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - Addressed by: Humana – CareSource Quality Member Access Committee Charter 2013 and HCS QMAC /Consumer Council minutes.	Full	Humana submitted Report #21 MCO Committee Activityt to DMS for Q2, Q3 and Q4 2014. The reports contained QMAC meeting minutes for 2 meetings held in September 2014 with members in attendance identified.	
20.8 Assessment of Member and Provider Satisfaction and Access				

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**
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 - Addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35-36) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program (p. 12, 21 – oversight by ED QMC) • 2013 HCS QI Program Evaluation o p. 17 – provider o p. 21 – member • 2013 HCS QAPI Work Plan o Provider Satisfaction Survey is being conducted by the Myers Groups, 1st qtr. 2014 o Member Satisfaction Survey will be performed by the Myers Group in early 2014	Full	Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys Addressed in the 2014 QI Program Description, pages 21, 36 and 38 and in the 2014 QI Work Plan, pages 9, 11, 12, 15 and 22. Evidenced in submission of Report #95 Provider Surveys to DMS in Q3 2014. Findings are described above in review element # 19.2 Annual QAPI Review. Evidenced in Report #94 Member Surveys to DMS in Q3 2014. Findings are described above in review element # 19.2 Annual QAPI Review.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	NA - Surveys will be conducted by the Meyers Group in early 2014.	Full	Evidenced in submission of Report #94 Member Surveys to DMS in Q3 2014.	

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**
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	Full - The MCO is conducting a BH survey and a case management (CM) survey, both through Myers Group. The case management survey includes members that were active in CM in 2013 and assesses member satisfaction with the CM process; goals met and improvement in care.	Full	Humana conducted special surveys of BH Member Satisfaction and Case Management Member Satisfaction with Program Surveys in 2014. Reports for both surveys were submitted to DMS in Q4 2014.	
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.	NA - Surveys will be conducted by the Meyers Group in early 2014.	Full	Evidenced in submission of Report #95 Provider Surveys to DMS in Q3 2014.	
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. A description of the methodology to be used in 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.	NA - Surveys will be conducted by the Meyers Group in early 2014.	Full	Evidenced in submission of Report #95 Provider Surveys to DMS in Q3 2014; submission of Report #94 Member Surveys to DMS in Q3 2014; and submission of special surveys of BH Member Satisfaction and Case Management Member Satisfaction with Program Surveys to DMS in Q4 2014.	
All survey results must be reported to the Department,	NA - Surveys will be	Substantial	Reporting survey results to DMS for each	Humana-CareSource agrees with this recommendation and

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**
and upon request, disclosed to Members.	conducted by the Meyers Group in early 2014. **Recommendation for Humana CareSource** Language regarding disclosure to members should be included in the 2014 Program Description. **MCO Response**: Humana-CareSource information on survey disclosure to members will be included in the KY QIPD MCD addendum with next version update.		of the survey types is addressed in the QI Work Plan, as described previously. Notation of disclosure to members upon request was not found in the 2014 or 2015 QI Program Descriptions or in the 2014 QI Work Plan. Evidenced in submission of Report #95 Provider Surveys to DMS Q3 2014; submission of Report #94 Member Surveys to DMS Q3 2014; and submission of special surveys of BH Member Satisfaction and Case Management Member Satisfaction with Program Surveys to DMS Q4 2014. **Recommendation for Humana** Humana should include the contract requirement that survey results will be disclosed to member upon request in one or more of its QI program documents. **Final Review Determination** No change in review determination. Humana should proceed with the plan to include the required language in the QI Program Description. Upon the next review, IPRO will evaluate	has added the information that survey results will be disclosed to member upon request in the 2015 QI Program Description.

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**
			the QI Program Description to ensure same.	
37.5 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.	Substantial - Language regarding submission of quarterly status reports to the Department (and submission format) is not found. Quarterly submission of reports (e.g., reports, high-level variance reports, and status reports) internally is noted throughout: 2013 Quality Improvement Program, Humana CareSource and 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. **Recommendation for Humana CareSource** The QI Program Description and Work Plan should include quarterly reporting	Full	Addressed in the 2014 QI Program Description on pages 37 and 38; in the draft 2015 QI Program Description on pages 8 and 19; and in the 2014 Work Plan on page 1 and throughout the document. Evidenced in the 2014 Work Plan on page 1 for the primary QI documents (QI Program Description and QI Work Plan and updates) and throughout the document for other relevant QI reports. Evidenced in submission of quarterly reports to DMS.	

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
	to the Department. **MCO Response**: Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly submissions to KDMS of Report #16, 17, & 18. Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by the submission of Report 84 on or before July 31, 2014. Final Review Determination: No change in compliance level. Humana-CareSource submitted the quarterly reports of the QAPI Program and Work Plan as described, however, Humana-CareSource should include the submission of these quarterly reports to DMS in its QI Program Description and QI Work Plan as stated in the original findings and recommendation.			

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	81	6	2	0
Total Points	243	12	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		**2.89**		

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
QI Work Plan
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports
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
Innovative Program description and status report

Reports

Annual QI Evaluation Report
HEDIS Final Audit Report and IDSS rates
Healthy Kentuckians Outcomes Measures Report
CAHPS Report
Provider Satisfaction Survey Report
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Performance Measure Reporting
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 service

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**
24. General Requirements for Grievances and Appeals	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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.	Full-2014			
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf. KAR 17:010 Section 4 (18)	Full-2014			
24.1 Grievance and Appeal Policies and Procedures				

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 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 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-2014			
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member. KAR 17:010 Section 4 (2), (4) (a) and Section 15 (1)	Full-2014			
A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate	Full-2014			

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**
representative of a deceased Member as parties to the appeal. KAR 17:010 Section 4 (4) (a), (5) , (6), and Section 15 (1)				
A. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	New Requirement	Full	This requirement is addressed in the Member Grievance – Customer Advocacy Operations Policy.	
B. 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;	New Requirement	Full	This requirement is addressed in the Member Grievance – Customer Advocacy Operations Policy.	
C. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
D. 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-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
E. Process for informing Members, orally and/or in writing, about the MCO's Grievance and Appeal Process by making information readily available at the MCO'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-2014			

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**
F. Provide assistance to Members in filing a grievance if requested or needed;	Full-2014			
G. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Substantial - For grievances addressed in Policy Number (SO – 20): Service Operations – Member Grievance – Kentucky which states: "CareSource will ensure that no punitive or retaliatory action is taken against a member or service provider that files a grievance or appeal or a provider that supports a Member's grievance." For appeals addressed in Policy Number (SO-19) Service Operations – Member Appeal Kentucky which states: "Neither members, their authorized representatives nor providers filling appeals on behalf of members will be subject to punitive or retaliatory actions as the result of exercising their grievance and appeal rights." Communicated to members in the Member Handbook on pg 42 which states: "…punitive or retaliatory action will not be taken against: a Member or service provider that files a grievance or an appeal; or a provider that supports a Member's grievance or appeal."	Full	This requirement is addressed in the Provider Manual.	

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**
	Evidence of communication of this policy to providers was not evident in the documentation provided. **Recommendation for Humana CareSource:** This policy should be communicated to providers in the Provider Manual or provider agreement. **MCO Response:** Humana-CareSource agrees with this recommendation. Language will be added to the Provider Manual.			
The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal. 42 CFR 438.410 (b)	Full-2014			
H. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full-2014			
I. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full-2014		Includes Member Grievance Random and Member Grievance Quality file review results	
J. Provide for an appeal of a grievance decision if the Member	New Requirement	Full	This requirement is addressed in 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**
is not satisfied with that decision;			Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy (QI-01).	
K. Provide for continuation of services, if appropriate, while the appeal is pending; The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Full-2014			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to	Non-Compliance - QI-01, on page 5 item h(ii): the MCO will provide benefits until 10 days have passed following Humana CareSource mailing the notice of an adverse appeal decision to the member. The P/P refers to Ohio instead of Kentucky and states 10 days instead of 14 days.	Full	This requirement is addressed in the Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy under section (j)(ii). Additionally, Humana has made this policy specific to only 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**
the Member; (4) The time period or service limits of a previously authorized service has expired. 42 CFR 438.420 KAR 17:010 Section 4 (14)	**Recommendation for Humana Care Source** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include Kentucky-specific requirement of 14 days after mailing. **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirement of 14 days after mailing. Non-Compliance - Addressed in QI-01 however the policy refers to Ohio instead of Kentucky on page 5 items h(ii) and h(iii). Discussion of KY statutes or KY fair hearing is not included. **Recommendation for Humana Care Source** In general, the combination of OH and KY			

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**
	requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, "the Cabinet issues a state fair hearing decision adverse to the Member;" **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirements around state fair hearings.			
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Non-Compliance - Addressed in QI-01 but refers to Ohio and OH-specific requirements only, not Kentucky on page 5 item j. **Recommendation for Humana CareSource** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements.	Full	This requirement is addressed in the Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy. Humana has made this document specific to 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**
	Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)." **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)."			
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as	Full-2014			

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**
expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424				
L. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being; If the Contractor denies a request for an expedited resolution of an appeal, it shall: (1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and (2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file. KAR 17:010 Section 4 (16)	Full-2014			
M. Provide written notice of the appeal decision;	Full-2014			
N. Provide for the right to request a hearing under KRS	Full-2014			

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**
Chapter 13B; and				
O. Provide for continuation of services, if appropriate, while the hearing is pending. The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Full-2014			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired.	Non-Compliance - QI-01, on page 5 item h(ii): the MCO will provide benefits until 10 days have passed following Humana CareSource mailing the notice of an adverse appeal decision to the member. The P/P refers to Ohio instead of Kentucky and states 10 days instead of 14 days. **Recommendation for Humana Care**	Full	This requirement is addressed in the Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy under section (j) (ii). Additionally, Humana has made this policy specific to only 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**
KAR 17:010 Section 4 (14) 42 CFR 438.420	**Source** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include Kentucky-specific requirement of 14 days after mailing. **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirement of 14 days after mailing. Non-Compliance - Addressed in QI-01 however the policy refers to Ohio instead of Kentucky on page 5 items h(ii) and h(iii). Discussion of KY statutes or KY fair hearing is not included. **Recommendation for Humana Care Source** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes			

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**
	incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, "the Cabinet issues a state fair hearing decision adverse to the Member;" **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirements around state fair hearings.			
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Non-Compliance - Addressed in QI-01 but refers to Ohio and OH-specific requirements only, not Kentucky on page 5 item j. **Recommendation for Humana CareSource** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO	Full	This requirement is addressed in the Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy. Humana has made the document specific to 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**
	procedures and processes. The policy should include the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)." **MCO Response:** Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)."			
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny,	Full-2014			

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**
limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424				
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.	Full-2014			
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or 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.	Substantial - Addressed in SO- 19 Service Operations – Member Appeal Kentucky, "All grievance and appeal files include, at a minimum: Member Name, Member ID, Reason for grievance or appeal, all supporting Documentation, Required Resolution and Member right to file an appeal or request a State Fair Hearing." The policy does not address: 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 notices of final decision to the Member. Addressed in QI-01: "CareSource will maintain a record for each clinical appeal	Full	This requirement is addressed in the Member Appeal – Customer Advocacy Operations Policy.	

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
	that includes: i. The name of the patient, provider and/or the facility rendering service; ii. Copies of all correspondence from the patient, provider, or facility rendering service including all documents regarding the clinical appeal that were utilized in the investigation of the appeal including any aspects of the clinical care involved; iii. Dates of clinical appeal reviews, documentation of actions taken, and final resolutions; and iv. Name and credentials of the clinical peer v. The clinical appeals case will be documented in the electronic documentation system. Policy does not explicitly state: notice to the Member of receipt of the grievance or appeal." **Recommendation for Humana Care Source** Policies should be revised to be consistent and to address all the requirements of the standard. **MCO Response:** Humana-CareSource agrees with this recommendation. Policies will be revised to be consistent and to address all the requirements of 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**
	standard.			
Documentation regarding the grievance shall be made available to the Member, if requested.	Substantial - Not addressed in Policy Number SO – 20: Service Operations – Member Grievance – Kentucky: "The records will be made available upon request to the Commonwealth or its designee. Policy does not address availability for members." Availability of documentation related to appeals is explicitly addressed in Policy Number QI-01 Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals: "Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based." Addressed in SO-19 which states: "CareSource 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. CareSoursce	Full	This requirement is addressed in the Customer Advocacy – Member Pre Service/Post Service Standard and Expedited Appeals Policy.	

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**
	shall include as parties to the appeal any individuals referenced in Section 3 of this policy." **Recommendation for Humana CareSource** The P/Ps should be consistent and address availability of documentation in the file to members for grievances. **MCO Response:** Humana-CareSource agrees with the recommendation. Policy will be updated to reflect the availability of documentation in the file to members upon requests for grievances.			
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)	Full-2014		Includes Member Random and Member Quality Grievance file review results	
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	Substantial - Addressed in SO-20. Member Grievance File Review-Quality 10/10 files did not include information on the investigation. This information is maintained separately by the QI	Full	Includes Member Random and Member Quality Grievance file review results This requirement is addressed in the Member Grievance – Customer Advocacy Operations Policy.	

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**
investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	department on the QMS system. During the onsite file review, QI staff presented details of the investigation and closure for each of the files via the QMS system. None of the files resulted in a confirmed quality concern. Two cases appeared to require further follow-up. In one case, the member was not aware of test results or why blood work and medications were needed. In this case, the MCO could have contacted the provider and requested that the provider discuss the testing and medications with the member. In another case, the case was classified as an attitude concern and no records were requested or reviewed. This case did appear to be a medical concern rather than an attitude concern. The MCO stated that this case would be re-opened. The resolution notices to members contain generic language and do not provide details regarding the investigation or outcome – "This letter is dealing with your recent complaint. An investigation has been completed dealing with your concerns. Your complaint was reviewed by a skilled health care expert. We cannot report the exact actions		<u>Member Grievance File Review Results - Random</u> 10/10 files contained information on the investigation as well as the findings and conclusion based upon the investigation and the disposition of the grievance. <u>Member Grievance File Review Results - Quality</u> 10/10 files contained information pertaining to the investigation and were supported by relevant QI investigatory materials when applicable. The resolution notices for all files reviewed (20/20) include member-specific language that provides details regarding the members' investigations and outcomes.	

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**
	taken. We have to keep these steps private. We can tell you that your complaint was completely reviewed. Proper action was taken. Thank you for your input. Input from Members improves our quality. Humana CareSource is committed to giving Members the best quality care." <u>Member Grievance File Review-Random</u> 10 files were reviewed. Two issues were identified. In one file, the file and resolution notice indicate that the complaint regarding rudeness of a representative would be investigated however there is no evidence in the file that this was done or a referral made to the relevant department. In another file, a member requested disenrollment and was verbally provided with the phone number for KY Medicaid. However, in the written notice, the section for the phone number was not completed. **<u>Recommendation for Humana Care Source</u>** The MCO should ensure that all concerns presented by the member are addressed and that concerns are appropriately classified and investigated.			

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**
	Humana CareSource should consider providing some details in the resolution notice when there is an opportunity to educate a member or provide clarification. **MCO Response:** During the onsite file review, QI staff presented details of the investigation and closure for each of the files via the QMS system. None of the files resulted in a confirmed quality concern. Humana CareSource believes that it has a clear process on how we identify, classify, and investigate member concerns. However, after the audit Humana CareSource reviewed the Policy and Procedures associated with this review and implemented enhancements to include a review process to ensure that a member's complaint is thoroughly reviewed. It is Humana-CareSource's policy to not disclose details of the investigation and resolution of a member grievance against a provider. However, upon reviewing the template grievance letter Humana CareSource agrees to review the letters and consider providing some detail,			

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**
	especially if there is an opportunity to educate or provide clarification to the member.			
The Contractor may extend by 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 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)	Non-Compliance - Not Addressed in SO-20. Per MCO, MCO contract with DMS does not include this requirement. Upon review of the document "Final Humana Contract for Region 3 (3).docx" and confirmation with DMS, it was determined that the contract does contain this requirement: contract section 24.1 Grievance Process and section 24.2 Appeal Process each state: "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 Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe." **Recommendation for Humana CareSource:** HCS should add the above language to its P/P SO-20 and ensure that written	Full	Includes Member Random and Member Quality Grievance file review results This requirement is addressed in the Member Grievance – Customer Advocacy Operations Policy. Member Grievance File Review Results - Random No files contained requests for extensions from either the member or Humana. Member Grievance File Review Results – Quality No files contained requests for extensions from either the member or Humana.	

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**
	notification within 2 days is provided to the member in the case of an extension for grievance resolution not requested by the member. **MCO Response:** Humana-CareSource agrees that the 2013 MCO contract language was not in the Policy SO-20. However, this language is not included in the 2014 contracts between KDMS and Humana. Therefore, Humana-CareSource does not see the need to add the above language to its P/P SO-20 and ensure that written notification within 2 days is provided to the member in the case of an extension for grievance resolution not requested by the member.			
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		Includes Member Appeal file review results	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor	Full-2014		Includes Member 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**
to resolve the appeal. KAR 17:010 Section 4 (7)				
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)	Substantial - Addressed in SO-19 however the policy does not state that the notice of extension will be mailed within two working days of the decision to extend the timeframe for regular/non expedited appeals only for expedited appeals. Member Appeal File Review None of the files reviewed required an extension. **Recommendation for Humana CareSource** The policy should include the required language regarding written notice within 2 working days for extensions not requested by the member: "…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." **MCO Response:** Humana-CareSource agrees with this recommendation. We will update the policy to include the following language "…shall give the	Full	Includes Member Appeal file review results This requirement is addressed in the Member Appeal – Customer Advocacy Operations Policy. Member Appeal File Review Results 10/10 files were fully compliant with this standard. One file out of ten was an expedited file and met all requirements.	

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 written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.			
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-2014		Includes Member Appeal file review results	
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 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)	Substantial - Addressed in SO-19 which states: "CareSource 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. CareSoursce shall include as parties to the appeal any individuals referenced in Section 3 of this policy." P/P QI-01 also addresses this requirement generally, but does not address all the specific elements of the requirement: "For clinical appeal upheld determinations, the organization issues written notification of the appeal	Full	Includes Member Appeal file review results This requirement is addressed in the Member Appeals and Member Grievances Policies as well as in the Member Pre Service/ Post Service Standard and Expedited Appeals Policy. <u>Member Appeal File Review Results</u> 10/10 files were compliant with this standard.	

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**
	decision to the member, the member's physician and/or other ordering provider or facility rendering service that includes: Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based" P/P QI-01 does not specify that: - This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member and his or her representative, or the legal representative of a deceased Member's estate. <u>Member Appeal File Review</u> 12/12 files were compliant. **<u>Recommendation for Humana CareSource</u>** The MCO should revise policy QI-01 to include all required elements of the requirement for member access to appeal records:			

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**
	- This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member and his or her representative, or the legal representative of a deceased Member's estate. **MCO Response:** Humana-CareSource agrees with this recommendation. We will revise the policy to include all required elements of the requirement for member access to appeal records: - This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member and his or her representative, or the legal representative of a deceased Member's estate.			
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.	Substantial - Addressed in SO-19 which states: "For all appeals, CareSource shall provide written notice within the 3 (policy states 3 not 30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal."	Full	Includes Member Appeal file review results This requirement is addressed in the Member Appeals – Customer Advocacy Operations Policy.	

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**
KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Member Appeal File Review 12/12 files were compliant. **Recommendation for Humana CareSource** The MCO should correct the apparent typographical error in the written notice timeframe (3 versus 30 days). **MCO Response:** Humana-CareSource agrees with this recommendation. The apparent typographical error in the written notice timeframe (3 versus 30 days) will be corrected.		Member Appeal File Review Results 10/10 files were fully compliant for this standard.	
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)	Substantial - Addressed in QI-01. Member Appeal File Review See subcomponents below. **MCO Response:** Humana-CareSource agrees with this recommendation. Resolution notices will be updated to include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. Minimal - Addressed in SO-19 and communicated to members in the	Substantial	Includes Member Appeal file review results This contractual requirement is addressed in the Member Appeals and Member Grievances Policies as well as in the Member Pre Service/ Post Service Standard and Expedited Appeals Policy. Member Appeal File Review Results 10 of 10 files contained information on the right to request a state fair hearing and how to do so.	Humana-CareSource agrees with this determination as the appeal resolution letters were not approved for utilization during 2014. The letters were approved by KDMS 3/31/2015 and implemented 4/7/2015. In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe.

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 Handbook. Member Appeal File Review Files did not address member liability. **Recommendation for Humana CareSource** Resolution notice should include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. **MCO Response:** Humana-CareSource agrees with this recommendation. Resolution notices will be updated to include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan.		10 of 10 files contained information on the right to request receipt of benefits while the state fair hearing is pending and how to make said request. 0 of 10 files addressed member liability and that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds Humana's actions. **Recommendation for Humana** Resolution notices should include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of Humana. Onsite, Humana presented a resolution notice (revision date October 2014) that contains the language pertaining to the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of Humana. This letter is pending approval from DMS.	
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.	Full-2014		Includes review results for Member Appeals if expedited	

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**
KAR 17:010 Section 4 (14) (c)				
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-2014		Includes review results for Member Appeals if expedited	
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-2014		Includes review results for Member Appeals if expedited	
24.2 State Hearings for Members				
A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. A Member may request a State Fair Hearing 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 Member's request for a State Fair Hearing must include a copy of the Contractor's final appeal decision. Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law	Non-Compliance - Not Addressed in Policy Number QI-19 or other documents provided. **Recommendation for Humana** Requirement should be addressed in a policy/procedure. **MCO Response:** Humana-CareSource agrees with this recommendation. The policy will be updated to include the following language, "Failure of the	Full	This requirement is addressed in the Quality Improvement – State Fair Hearing Procedure Policy.	

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 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.	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".			
27.8/27.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that all appeals from Providers are reviewed. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. Appeals received from Providers that are on the Member's behalf with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals in a written record with the 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 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	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 Appeal 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**
shall submit quarterly reports to the Department regarding the number, type and outcomes of Provider grievances and appeals. A Provider does not have standing to request a State Fair Hearing for appeals that fall under the scope of this Section.				
27. 9/27.10 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-2014			
37.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances 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.	New Requirement	Substantial	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeal Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Grievance and Appeal Activity Reports submitted by the MCO. A review of the Member Grievance Activity Reports finds that the majority of grievances are related to network availability and identification (ID) cards. The MCO was taking initiative to assist members with locating participating	Humana - CareSource agrees with the recommendation. The additional analysis documentation will be incorporated in future G&A committee minutes and the quarterly KY reports.

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**
			providers when a preferred provider was not participating. The MCO is also doing a returned mail analysis in order to track ID card related issues. A review of the Member Appeal Activity Reports finds that the majority of the MCO's appeals are related to pharmacy. Reports #27, #28 and #29 are reviewed with quarterly desk audits conducted by IPRO. Recommendations based on the review are below. **Recommendation for Humana** Actions taken by the MCO in response to analysis of grievances should be more specific. For example, the MCO's actions of working with Provider Relations to report access trends and Networking to update provider profiles should be detailed. It is not clear how or to whom access trends are being reported or how the provider profiles are being updated. 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	

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**
			grievances resolved within 30 days.	
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.	New Requirement	Full	This requirement is addressed in the Member Appeals Policy.	

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	17	2	0	0
Total Points	51	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance

Final Findings

Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.89		

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

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

Final Findings

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

Reports

Quarterly reports of grievances and appeals

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
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
34.1 Health Risk Assessment (HRA)	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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-2014			
The Contractor shall conduct initial health screening assessments including mental health and substance use disorder screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. If the Contractor has a	Minimal - Per P/P W-01, "the MCO will conduct initial health screening assessments of new members who have not been enrolled in the prior twelve (12) month period for the purpose of assessing the member's need for any special health care needs and within ninety (90) days of enrollment. Members who CareSource has a	Substantial	Includes HRA file review results This requirement is addressed in the Wellness – Health Screening Assessment (W -01), Member Welcome Packet Mailings 2014 and Humana-CareSource Health Assessment.	Humana - CareSource (HCS) agrees with the recommendation. HCS will finalize and implement the proposed additional actions, which include: - a 4-week reminder letter - web-based HRA - on hold HRA messaging for member

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**
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.	reasonable belief to be pregnant shall be screened within thirty (30) days of enrollment, and if pregnant, referred for appropriate prenatal care." Per section E.6, the information collected will be used to determine the members' need for care management, disease management, behavioral health services and/or other any other health or community services. The New Member Kit, which contains a health risk assessment (HRA), is sent to the new member within a week of identifying the member on the 834 Eligibility File. Within two weeks, additional HRA surveys are sent to members who live in the same household and all members who do not respond to the original attempt. If still not returned, no further outreach until a trigger event occurs. HRA is also available on the MCO's web portal. Humana CareSource tracks date of initial mailing but not subsequent mailings. The HRA outreach process is currently under review. HRA File Review Of the 30 files requested, only 2 had completed HRAs. **Recommendation for Humana CareSource** Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked.		HRA File Review Results A total of 25 files were reviewed. 25/25 files included evidence of a timely initial outreach attempt. 25/25 files receiving initial outreach included timely follow-up attempts when the initial attempt was unsuccessful. Both attempts, initial and follow-up, are by mail. None of the files requested had completed HRAs. As was noted last year, the Welcome Packet mailing includes an HRA and the 2-week reminder letter includes another HRA. In late November 2014, the MCO implemented an HRA reminder as part of welcome calls. A member newsletter article was issued in Q1 2015. In addition the following actions are planned: - a 4-week reminder letter - web-based HRA - on hold HRA messaging for member services - HRA flier to be distributed at member events. **Recommendation for Humana** Humana should finalize and implement the proposed additional actions noted above.	services - HRA flier to be distributed at member events.

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**
	MCO Response: The contract indicates "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. Humana – CareSource (HCS) believes that the 2 mailings and publication of the HRA on our web site meets the contract requirement language of reasonable attempts and requests that this standard be moved to full compliance. Although the contract requirement is for reasonable attempt, HCS has explored additional options for improving the rate of HRA completion by members in order to proactively identify members who could benefit from services offered by HCS. HCS has explored several options for improving the rate of HRA completions. These include: • Use of IVR technology to outreach to members to encourage the completion of the HRA is planned for fourth quarter 2014. • During May 2014, two temporary staff were brought on board to make live outbound welcome calls to encourage member completion of an HRA during the call. HCS will evaluate the continuation of live calls based on impact to the HRA completion rate. • Addition of an interactive web based Member Health Assessment 1st Qtr. 2015.			

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**
	Final Review Determination: No change in compliance level. Humana-CareSource was only able to present 2 completed HRAs of 30 requested. This meets the requirement for conducting an initial HRA minimally. This finding was reviewed with DMS.			
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 and the survey instrument for both substance use and mental health disorders.	Minimal - Per P/P W-01, HRAs and a pre-addressed, prepaid return envelope are included in new member kits mailed to all new members at enrollment. Member follow up is done by mail, internet, phone and\or in person. Goal is for HRA completion within 90 days; 30 days for members identified as pregnant. Per the minutes to the Medicaid Compliance and Report/Monitoring & Audit Committee meeting dated 12/17/13, members receive an HRA in the New Member Kit within 1 week of enrollment and 2 follow up letters & HRA form within 2 weeks. High risk members receive a follow up phone call if there is no response within 2 weeks. During the onsite review the process was explained as: A Welcome packet is sent within one week of enrollment. Two weeks later the HRA is sent for all members in the household. If still not returned, no further outreach until a trigger event occurs. The HRA is also available on web portal. Completion of an HRA is promoted in member newsletters. Phone f/u or in person	Substantial	Includes HRA file review results This requirement is addressed in the Health Risk Assessment (HRA) Status Update and Wellness – Health Screening Assessment (W -01) on pages 1-2. Current Initiatives include: - Welcome Packet mailing is tracked and includes HRA Letter and one HRA - 2 week reminder letter with HRA for all family members Welcome calls include a request for the member to complete the HRA - Direct calls to known pregnant members within the first 30 days of enrollment - Member newsletter article - Reminder/request for HRA during calls to pregnant members regarding the scheduling of their prenatal visit - Request to complete HRA included with all case management outreach. HRA File Review Results	Humana - CareSource (HCS) agrees with the recommendation. HCS will finalize and implement the proposed additional actions, which include: - a 4-week reminder letter - web-based HRA - on hold HRA messaging for member services - HRA flier to be distributed at member events.

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**
	attempts are not currently used. Humana CareSource tracks date of initial mailing but not subsequent mailings. The MCO reported that the outreach process for conduct of an HRA is currently under review. The MCO is recruiting for a staff person to conduct welcome/outreach calls. In addition, by October 2014, Humana CareSource intends to offer completion of the HRA online to its members. <u>HRA File Review</u> A total of 30 files were requested. Of the 30 files, only 2 enrollees had completed HRAs. For the remaining 28 files: 7 members were mailed a Welcome packet within one week of enrollment; 18 members were mailed a Welcome packet but the mailing date was greater than one week of enrollment /eligibility; two members had a mailing date of UTD and one had a date of NA per documentation provided by the MCO. As noted above, subsequent mailings are not tracked. Quarterly reports indicate the following completion rates: Q1 2013: 305 completed after reasonable effort/12665 new HRAs initiated; 2% Q2 2013: 349/2019; 17% Q3 2013: 368/1445; 25% Q4 2013: 98/1464; 7%		A total of 25 files were reviewed. 25/25 files included evidence of a timely initial outreach attempt. 25/25 files receiving initial outreach included timely follow-up attempts when the initial attempt was unsuccessful. Both attempts, initial and follow-up, are by mail. None of the files requested had completed HRAs. As was noted last year, the Welcome Packet mailing includes an HRA and the 2-week reminder letter includes another HRA. In late November 2014, the MCO implemented an HRA reminder as part of welcome calls. A member newsletter article was issued in Q1 2015. In addition the following actions are planned: - a 4-week reminder letter - web-based HRA - on hold HRA messaging for member services - HRA flier to be distributed at member events. Humana has consistently reported nearly 90% of HRAs not completed after reasonable efforts in its quarterly submissions of MCO Report #79. **<u>Recommendation for Humana</u>** Humana should finalize and implement the	

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
	Recommendation for Humana CareSource Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked. Humana CareSource should ensure that Welcome packets are mailed within one week of enrollment/eligibility. **MCO Response:** See Above. Final Review Determination: No change in compliance level. Only one method of attempted contact was employed – mailing the HRA. Website posting does not meet the requirement for outreach thought it is a good supplemental action. Additionally, the MCO could only provide tracking information/evidence of outreach for one mailed attempt. The outcome of 2 completed HRAs of 30 requested does not provide evidence of all reasonable attempts. This finding was reviewed with DMS.		proposed additional actions noted above. **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.	
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	Full-2014		Includes HRA file review results	

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**
or community services.				
The Contractor shall use appropriate healthcare professionals in the assessment process.	Full-2014			
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative 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			
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-2014		Includes review of MCO Report #79 Health Risk Assessments	

Final Findings

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	0	2	0	0
Total Points	0	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		**2.0**		

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

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
27.2 Provider Credentialing and Recredentialing	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
In compliance with 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. This documentation shall include, but not be limited to,	Full-2014			
defining the scope of providers covered,	Full-2014			
the criteria and the primary source verification of information used to meet the criteria,	Full-2014			
the process used to make decisions and the extent of delegated credentialing and recredentialing	Full-2014			

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**
arrangements.				
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.	Full-2014			
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Full-2014			
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-2014			
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-2014			
B. The process for verification of Provider credentials and insurance, and any additional facts for further	Full-2014			

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**
verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.				
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 additional information as may be specified by the Department.	Full-2014			
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 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.	Full-2014			
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-2014			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2014			
C. A review of the credentialing policies and procedures by the formal body;	Full-2014			

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**
D. A credentialing committee which makes recommendations regarding credentialing;	Full-2014			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2014			
F. Written procedures for the termination or suspension of Providers; and	Full-2014			
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-2014			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Full-2014		Includes Credentialing file review summary results	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Minimal - The Credentialing Policy 2013 does not address licensure/certification in the Commonwealth of Kentucky, specifically. The P/P lists requirements for state licensure and verifying state licensure in general. Credentialing File Review 20/20 files were compliant. **Recommendation for Humana CareSource** The Credentialing Policy 2013 should be updated to specifically address the	Full	This requirement is addressed in the Credentialing 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**
	requirement that the practitioner have a current valid license or certificate to practice in the Commonwealth of Kentucky. **MCO Response:** Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "When a provider practices in the state of Kentucky, Credentialing Operations will verify the provider has a current valid license or certificate to practice in the Commonwealth of Kentucky before making a credentialing or recredentialing decision. Credentialing Operations will verify out of state providers have a current valid license issued by the state in which they practice.			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2014			
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-2014			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2014			

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**
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;	Non-Compliance - Not addressed in Credentialing Policy. **Recommendation for Humana CareSource** The Credentialing Policy should be updated to address the requirement of a 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. **MCO Response:** Humana & CareSource are currently researching this requirement to ensure the best policy and procedure is put into place. Once the research is complete, a P&P will be published.	~~Full~~ Not Applicable	This requirement is addressed in the Credentialing Policy. **Final Review Determination** Upon discussion with DMS, this requirement is Not Applicable.	
F. Previous five (5) years work history;	Full-2014			
G. Professional liability claims history;	Full-2014			
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-2014			
I. Current, adequate malpractice insurance, as verified through attestation;	Full-2014			

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**
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2014			
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2014			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2014			
M. Documentation of censure by the State or County professional association; and	Full-2014			
N. Most recent information available from the National Practitioner Data Bank.	Full-2014			
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;	Full-2014			
B. Lack of present illegal drug use;	Full-2014			
C. History of loss of license and felony convictions;	Full-2014			
D. History of loss or limitation of privileges or disciplinary activity;	Full-2014			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2014			
F. Applicant attests to correctness and completeness of the application	Full-2014			
Before a practitioner is credentialed, the Contractor shall verify information from the following				

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**
organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full-2014			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full-2014			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2014			
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-2014			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Not Applicable - Not applicable as per Humana. Per DMS, the OIG conducts this structured review.			
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.	Full-2014			
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-2014		Includes Recredentialing file review summary results	

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**
A. A current license to practice;	Full-2014			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2014			
C. A valid DEA number, if applicable;	Full-2014			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2014			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Substantial - Credentialing Policy 2013 addresses this requirement stated as: "The practitioner has acceptable liability claims history" but does not address five years. During the onsite visit, the MCO advised that liability claims are held for 10 years. **Recommendation for Humana CareSource** Credentialing Policy should be updated to include the timeframe for verification of professional liability claims. **MCO Response:** Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "Before making a credentialing or recredentialing decision, Credentialing Operations will	Full	This requirement is addressed in the Credentialing 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**
	verify professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner for the previous 5 years are within acceptable standards.			
F. A current signed attestation statement by the applicant regarding:	Full-2014			
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2014			
2. The lack of current illegal drug use;	Full-2014			
3. A history of loss, limitation of privileges or any disciplinary action; and	Full-2014			
4. Current malpractice insurance.	Full-2014			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full-2014			
A. The national practitioner data bank;	Full-2014			
B. Medicare and Medicaid;	Full-2014			
C. State boards of practice, as applicable; and	Full-2014			

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**
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2014			
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.	Full-2014			
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.	Full-2014			
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-2014			
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating 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-2014			

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 have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Full-2014			
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-2014			
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.	Substantial - Not addressed in policy/procedure. CAT II example was submitted as a sample report to DMS of a case where a provider requires review by the Credentialing Committee. **Recommendation for Humana CareSource** Policy QM-288-01 Provider Quality Review Process and/or Credentialing Policy should be revised to address notification to the Department of facts and outcomes by the credentialing committee review based on quality criteria. **MCO Response:** Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "• If a provider requires review by Humana's Credentials Committee due to quality concerns,	Full	This requirement is addressed in the Credentialing 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**
	Credentialing Operations will notify the Kentucky Medicaid Enrollment office. Notification will include a summary of the facts and outcomes of the Committee's review and how the outcome supports the State's Medicaid credentialing process.			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2014			
28.1 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 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 if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. 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	Full-2014			

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**
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 agency, 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, Certified Peer Support Providers, Certified Parental Support Providers, and Licensed Clinical Social Workers. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members.				

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**
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 and certify 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 OSCAR file 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-2014			
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 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.	Full-2014			

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**
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-2014			
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.	Substantial - The documents provided do not address the requirement to offer participation agreements with currently enrolled Medicaid providers who have received EHR incentives. **Recommendation for Humana CareSource** A policy/procedure addressing enrollment of providers who have received EHR incentive funds should be developed. **MCO Response:** Humana-CareSource disagrees with this recommendation. We feel that our P&P Quarterly Non Par Report Review Process is broader than the contract requirement and therefore we are fully compliant. Humana-CareSource reaches out to any provider who is currently enrolled in the KY Medicaid Program for recruitment purposes. However, we are happy to add language that the providers currently enrolled in the KY Medicaid Program and also received electronic health record incentive funds are included in this recruitment initiative.	Full	This requirement is addressed in the Provider Recruitment 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**
	Final Review Determination: Substantial Compliance Humana-CareSource's procedure for outreaching any provider who is enrolled in Kentucky Medicaid for network recruitment does address fulfilling the requirement. However, to be fully compliant with the requirement, the MCO should add the wording regarding "EHR incentive" to its P/P.			
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.	Substantial - Policy MM-10 Medical Management - Out of Network Referrals and Negotiations addresses this requirement. However, the policy does not address a streamlined enrollment process to assign provider numbers for out-of-network providers. **Recommendation for Humana CareSource** Policy MM-10 should be updated to include the streamlined enrollment process for out of network providers. **MCO Response:** A hard copy of the KY Medicaid Enrollment policy (CR301) was provided to the auditors on site	Full	This requirement is addressed in the Medical Management – Out of Network Referrals and Negotiations Policy. The Kentucky Medicaid Enrollment documentation provides Appendix A – Streamlined Kentucky Medicaid Enrollment Process, a flow chart that indicates the step-by-step process of enrollment to assign provider numbers for out-of-network providers.	

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**
	3/27/14. Final Review Determination: No change in compliance level. Humana-CareSource did provide P/P CR301 during the onsite audit, however, language regarding the "streamlined enrollment process" was not found in the document.			
28.3 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-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	Full-2014			

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 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.				
28.4 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 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.	Full-2014			
28.5 Enrolling New Providers and Providers not Participating in Medicaid				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of	Full-2014			

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**
participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.				
28.6 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-2014			
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.	Not Reviewed	Full	This requirement is addressed in the Provider Lifecycle Management – Provider Termination Policy. Section 7.3 (page 3) of the Provider Agreement gives Humana the right to terminate the Provider, effective immediately.	
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider within three business days via email. The	Full-2014			

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**
Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.				
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.	Not Reviewed	Substantial	The Provider Lifecycle Management – Provider Termination Policy addresses this requirement in item 5. Missing from the documentation is evidence that Humana notifies the member of the provider's termination, provided such member has received a service from the terminated provider within the previous six months. **Recommendation for Humana** Humana's 2015 Member Handbook has been updated to include this regulatory requirement in its entirety. It is recommended that Humana finalize its Member Handbook and this standard be reevaluated with the next audit cycle.	Humana - CareSource agrees with the finding given that the Member Handbook updates were not approved for the 2014 contract year. The updates to the handbook were approved by KDMS on 03/18/15. On page 12 of the approved 2015 Member Handbook, it details that notification of the provider occurs within the regulatory and contractual timeframes. Currently our Provider Data Integrity Team initiates notification to affected members of provider terminations according to requirements. In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe.
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 as referenced in Appendix K. The Contractor shall indicate in its notice	Full-2014			

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**
to the Department the reason or reasons for which the PCP ceases participation.				
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.	Not Reviewed	Substantial	This requirement is addressed in the Provider Lifecycle Management – Provider Termination in item 7. Missing from the documentation is evidence that Humana notifies the member of the provider's termination, provided such member has received a service from the terminated provider within the previous six months. **Recommendation for Humana** Humana's 2015 Member Handbook has been updated to include this regulatory requirement in its entirety. It is recommended that Humana finalize its Member Handbook and this standard be reevaluated with the next audit cycle.	Humana - CareSource agrees with this determination as the updated handbook was not available for the 2014 contract year. At this time, Humana-CareSource is now fully compliant with this contract requirement as KDMS approved this new handbook on 03/18/15. On page 12 of the approved 2015 Member Handbook, it details that notification of the provider occurs within the regulatory and contractual timeframes. Currently our Provider Data Integrity Team initiates notification to affected members of provider terminations according to requirements. In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe.
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.	Not Reviewed	Full	This requirement is addressed in Section 7.4 of the Physician Provider Agreement addresses this requirement (page 3).	

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 terminating Provider 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.	Not Reviewed	Full	This requirement is addressed in the Provider Lifecycle Management – Provider Termination Policy.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

Final Findings

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	8	2	0	0
Total Points	24	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		**2.80**		

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
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
27.3 Primary Care Provider Responsibilities	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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	Full-2014			

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**
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.				
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-2014			
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-2014			
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-2014			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2014			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2014			

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**
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-2014			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2014			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2014			
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-2014			
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by 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-2014			
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical	Full-2014			

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**
practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and				
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.	Full-2014			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full-2014			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full-2014			
(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-2014			
(4) Returning after-hours calls outside of thirty (30) minutes.	Full-2014			
28.7 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 Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.	Full-2014			
The Contractor shall make available and accessible	Full-2014			

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**
facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.				
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-2014			
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members 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-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals.	Full-2014			
C. In addition to the above, the Contractor shall include in its network Specialists designated by the	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly	

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**
Department in no fewer number than 25% of the Specialists enrolled in the Department's Fee-for-Service program by 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 region, the 25% shall not apply to that region.			Desk Audit results)	
D. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Full-2014			
E. Access to hospital care shall not exceed 30 miles or 30 minutes of a Member's residence in an urban area, or 60 minutes of a Member's residence in a non-urban area, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed 60 miles or 60 minutes.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
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-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
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	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	

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**
hours for Urgent Care.				
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-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;	Full-2014			
B. FQHCs and rural health clinics;	Full-2014			
C. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2014			
D. Community Mental Health Centers	Full-2014			
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			
In consideration of the role that Department for Public Health, which contracts with the local health departments play 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				

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**
provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Full-2014			
B. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2014			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Full-2014			
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 in the service area 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			
28.8 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix G that demonstrates that the Contractor has an adequate network that meets the Department's standards in Section 28.7. The MCO shall notify the Department, in writing, of any	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	

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**
anticipated network changes that may impact network standards herein.				
The Contractor shall update this information to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.	Full-2014			
28.9 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 days the Contractor shall submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.	Full-2014		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results)	
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-2014			
30.1 Medicaid Covered Services				

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**
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.	Full-2014			
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 I 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 applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Full-2014			
After the Execution Date and the adjustment for ACA compliance, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder				

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**
will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, 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-2014			
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	Full-2014			

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**
to retain the form in the event of audit and a copy shall be submitted to the Department upon request.				
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-2014			
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, 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-2014			
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-2014			
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request.	Full-2014			

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**
Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).				
32.4 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-2014			
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-2014			
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. 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-2014			

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**
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member 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-2014			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full-2014			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2014			
D. Maternity care for Members under 18 years of age;	Full-2014			
E. Immunizations to Members under 21 years of age;	Full-2014			
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2014			
G. Tuberculosis screening, evaluation and treatment;	Non-Compliance - Not addressed in the Member Handbook. **<u>Recommendation for Humana CareSource</u>** Direct access for tuberculosis screening, evaluation and treatment should be addressed in the Member Handbook. **MCO Response:** We will add to our Member Handbook under Direct Access the following, "Tuberculosis screening, evaluation and treatment." A request to	Full	This requirement is addressed in the Member Handbook on page 68.	

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**
	revise the Member Handbook under Direct Access and add "Tuberculosis screening, evaluation and treatment" has been submitted.			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2014			
I. Chiropractic services; and	Full-2014			
J. Women's health specialists.	Full-2014			
32.6 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 I 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-2014			
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under 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-2014			
All information shall be provided to the Member in a	New Requirement	Minimal	The requirement that all information be	Humana - CareSource agrees with 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**
confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.			provided to members in a confidential manner is found in the Member Handbook and the Provider Manual. Missing from the documentation was the regulatory language pertaining to counseling and medical services. **Recommendation for Humana** Humana should add the regulatory language pertaining to counseling and medical service appointments to its Family Planning Policy as well as to its Provider Manual and Member Handbook.	determination given this information was not available for the 2014 contract year. Approval of the new Member handbook was obtained from KDMS on 03/18/15. Page 12 of 2015 Member Handbook details that notification of the provider occurs within the regulatory and contractual timeframes. The Provider Handbook is still with KDMS for approval. During a meeting with Wayne Dominick, KDMS, on 05/19/15, it was brought up that the 2014 Provider Manual has been with KDMS since December 2014 for review and approval. In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe.

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	0	1	0
Total Points	3	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		**2.0**		

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	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
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

Final Findings

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
Geo Access network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care
- 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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
20.6 Utilization Management	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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.	Full-2014			
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-2014			
The description shall include the scope of the program;	Full-2014			

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 processes and information sources used to determine service coverage;	Full-2014			
clinical necessity, appropriateness and effectiveness;	Full-2014			
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			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Full-2014			
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-2014			
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 or the QI Committee.	Full-2014			
The Contractor shall adopt Interqual, Milliman or other nationally recognized standards and criteria for Medical Necessity review which shall be approved by the Department.	Substantial - The Humana CareSource UM Program Description states that the plan uses nationally recognized standards and criteria; however, document does not address DMS approval. **Recommendation for Humana CareSource** The Program Description should include requirement for Department	Full	This requirement is addressed in the 2015 Humana-CareSource Kentucky Utilization Management Program Description on page 5 and 18-19.	

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**
	approval. Humana CareSource should make the DMS approval letter available for the compliance reviewer. **MCO Response:** Humana-CareSource agrees with this determination. Humana-CareSource will update the information in the overview section of the UM Program to reflect… "Outcome metrics, policy changes and other program modifications pertaining to Kentucky are reported throughout the year to the Kentucky Humana CareSource Quality Assessment Committee and will be submitted to the Kentucky Department of Medicaid Services for approval." This change will be submitted through the required approval process including the KDMS.			
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.	Full-2014			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2014			

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-2014		Includes UM file review results	
The Medical 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-2014		Includes UM file review results	
The reason for the denial shall be cited.	Full-2014		Includes UM file review results	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.	Full-2014			
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.	Substantial - This requirement is addressed in the Humana CareSource UM Program Description and the Medical Management - Medical Necessity Determination Policy. The MCO submitted the UMC PA data and Report Summary for QAC 7-2013. The MCO demonstrated 100% compliance for meeting timeframes for 4 out of 5 months for non-urgent authorization requests and 5 out of 5 months for urgent authorization	Full	This requirement is addressed in the 2015 Humana-CareSource Kentucky Utilization Management Program Description on pg. 18 and the Medical Management - Medical Necessity Determination Policy on pages 4-5. UM file within requirements –no expedited reviews. The UM Committee –Meeting Minutes for June 26, 14 demonstrated compliance for meeting timeframes for authorization requests.	

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**
	requests. UM File Review 9/10 files were processed timely. **Recommendation for Humana CareSource** UM decisions should be completed within the specified timeframes. **MCO Response:** Humana-CareSource agrees with this determination. Humana CareSource monitors timeframes for medical necessity reviews as outlined in the UM Program description and Medical Management – Medical Necessity Determination Policy. Should a failure to meet a timeframe occur, a root cause analysis and corrective actions are taken to remediate the issue. Quality auditing is performed as outlined in the Medical Management – Quality Monitoring of the Utilization Management Activities.			
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Substantial - The Humana CareSource UM Program Description states that "Outcome metrics, policy changes and other program modifications pertaining to Kentucky	Full	This requirement is addressed in the 2015 Humana-CareSource Kentucky Utilization Management Program Description on page 5.	

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**
	are reported throughout the year to the Kentucky Humana CareSource Quality Assessment Committee". **<u>Recommendation for Humana CareSource</u>** MCO should revise the UM Program Description to include any change to prior authorization requirement must be submitted to DMS for review. **MCO Response:** Humana-CareSource agrees with this determination. Humana-CareSource will update the information in the overview section of the UM Program to reflect… "Outcome metrics, policy changes and other program modifications pertaining to Kentucky are reported throughout the year to the Kentucky Humana CareSource Quality Assessment Committee and will be submitted to the Kentucky Department of Medicaid Services for approval." This change will be submitted through the required approval process including the KDMS.			

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**
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-2014			
C. In the event that a Member or Provider requests 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.	Full-2014			
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-2014			
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.	Substantial - The Humana CareSource UM Program Description states, "The UM Program is integrated with the following programs, Quality Improvement (QI)…", however, it does not explain, specifically, how prior authorization data will be incorporated into the overall Quality Improvement Plan. "RR CareSource Description Quality Improvement Program" addresses the incorporation of prior authorization/utilization data on	Full	This requirement is addressed in the 2015 Humana-CareSource Kentucky Utilization Management Program Description on pages 24-25.	

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**
	pages 11-12, under subcommittee descriptions: "Utilization Management Committee - The Utilization Management Committee (UMC) is charged with consideration and approval of decisions related to the Humana CareSource Utilization Management program including administrative and clinical direction, ensuring compliance with Federal, State, and accreditation requirements. The purpose is to ensure Humana CareSource utilization management programs and processes including review and development of clinical criteria used to make utilization review and appeal determinations are developed to promote the quality of care provided to Humana CareSource members consistent with standards of care, and are provided timely and consistently. The committee will measure, monitor and report utilization trends including over and under-utilization." On page 14: "Impact of the pharmaceutical management program including issues related to under- and over-utilization of services" And on page 35: "On an annual			

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**
	basis, Humana CareSource implements quality improvement projects and activities aside from those required by state and federal entities. Projects are chosen based on data analysis both internally and externally to determine what quality improvement activities to focus. Data from the following sources is routinely analyzed and results are used to identify opportunities for improvement: … 4. Utilization/Disease Management **Recommendation for Humana CareSource** Humana CareSource should revise the UM Program Description to specifically describe how prior authorization data is incorporated in the overall Quality Improvement Plan. **MCO Response:** Humana-CareSource agrees. Humana-CareSource will update the UM Program to provide a more detailed explanation as to how the UM data is incorporated into the overall QI plan.			
F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.	New Requirement	~~Substantial~~ Not Applicable	~~Clinical Trials Medical Policy Draft includes some but not all contract elements: clinical trial is a Phase III, or IV research study.~~	Humana - CareSource agrees with this finding. Humana - CareSource has updated the Clinical

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**
			~~Clinical Trials Medical Policy Draft does not include that the MCO shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.~~ ~~**Recommendation for Humana**~~ ~~Humana CareSource should revise the draft Clinical Trials Medical Policy or develop a policy that includes the contract language that pertains to providing coverage for randomized and controlled Phase III and Phase IV clinical trials.~~ **Final Review Determination** After discussion with DMS, this requirement is considered Not Applicable.	Trials Medical Policy and presented to the Clinical Policy Committee on 5/19/15. Anticipate final approval and execution by 6/15
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-2014			
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Full-2014			
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the	Full-2014			

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**
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-2014			
The UM program will be evaluated by DMS on an annual basis.	Full-2014		Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results)	
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice if an Action related to medical necessity or coverage denials that meets the language and formatting requirements for Member materials, of any 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-2014			
(a) The action the Contractor has taken or intends to take;	Full-2014		Includes UM file review results	
(b) The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2014		Includes UM file review results	
(c) The federal or state regulation supporting the action, if applicable.	New Requirement	Full	Includes UM file review results 6 of 6 were compliant. 4 files NA. This requirement is addressed in the Medical Management - Medical Necessity	

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**
			Determination Policy on page 7 and Medical Management – Member- Provider Notification of Initial Determinations on page 4.	
(d) The Member's right to appeal;	Full-2014		Includes UM file review results	
(e) The Member's right to request a State hearing;	Non-Compliance: This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure. UM File Review 10/10 files did not show evidence of member's right to a State Fair Hearing included in the notice. Humana advised during the onsite review that the member must exhaust the internal appeal process before requesting a State hearing. Confirmed with DMS that the initial adverse determination notice should inform the member of the right to a State hearing once the MCO appeal process is exhausted. **Recommendation for Humana CareSource** The initial adverse determination notice should include reference to the member's right to a State hearing if the member requests an appeal and the appeal upholds the decision.	Minimal	Includes UM file review results 1 of 10 of the UM Files in 2014 included the member's right to request a State hearing. During the onsite interview, the plan explained that a draft of the Notice of Action letter was submitted to the State in October and recently received state approval on 2/6/15. The MCO provided a copy of an email showing denial letter update approved by DMS on 2/6/15. This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 7, Medical Management – Member- Provider Notification of Initial Determinations on page 4 and Member Denial Letter Update Draft. **Recommendation for Humana** The initial adverse determination notice should include reference to the member's right to a State hearing.	The initial adverse determination notice should include reference to the member's right to a State hearing if the member requests an appeal and the appeal upholds the decision. **DMS Response** DMS has concerns with this requirement as it has been two years in a row for failure to correct.

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**
	MCO Response: Humana-CareSource disagrees with this determination. CareSource understands that a member must exhaust his/her appeal rights before requesting a state fair hearing. Currently, the initial denial letter contains information on filing an appeal, and the appeal upheld letter contains information on filing a state fair hearing. Originally, the letters contained information about both the appeal and the state fair hearing but it caused member confusion so the extraneous information was deleted. We think this is the most accurate and least confusing way to explain to members their rights and asks IPRO and the state to let our letters continue to include only the next step in the appeal process. Final Review Determination: No change in compliance level. It is correct that the member must exhaust the MCO appeal rights before requesting a state hearing. However, it was confirmed with DMS that at the time of initial denial, the MCOs must disclose the member's right to a SFH after exhausting the appeal rights. This can be communicated in one simple			

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**
	sentence. The entire SFH process need not be described.			
(f) Procedures for exercising Member's rights to Appeal or file a Grievance;	Full-2014		Includes UM file review results	
(g) Circumstances under which expedited resolution is available and how to request it; and	Full-2014		Includes UM file review results	
(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-2014		Includes UM file review results	
20.8 Timeframe for Notice of Action Related to Medical Necessity or Coverage Denials				
The Contractor must give notice of an Action related to medical necessity or coverage denials at least: A. Ten (10) days before the date of 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-2014			
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;	Non-Compliance - The requirement to give notice by the date of the action in the event of the death of a Member was not addressed in the P/P in 2013. However, during the	Full	This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 7 and Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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**
	onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 1.			
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);	Non-Compliance - The requirement to give notice by the date of the action in the event of a signed written Member statement was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending	Full	This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 7.	

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**
	approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 2.			
3. The Member's admission to an institution where he is ineligible for further services;	Non-Compliance - The requirement to give notice by the date of the action in the event of the Member's admission to an institution where he is ineligible for further services was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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**
	approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 3.			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Non-Compliance - The requirement to give notice by the date of the action in the event that the Member's address is unknown and mail directed to him has no forwarding address was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **<u>Recommendation for Humana CareSource</u>** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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**
	determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 4.			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Non-Compliance - The requirement to give notice by the date of the action in the event that the Member has been accepted for Medicaid services by another local jurisdiction was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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 language for Section B 5.			
6. The Member's physician prescribes the change in the level of medical care;	Non-Compliance - The requirement to give notice by the date of the action in the event that the Member's physician prescribes the change in the level of medical care was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 6.	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1,	Non-Compliance - The requirement to give notice by the date of the action in the event of an adverse	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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**
1989;	determination made with regard to the preadmission screening requirements for nursing facility admissions was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 7.			
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate 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.	Non-Compliance - The requirement to give notice by the date of the action in the event that the safety or health of individuals in the facility…, the Member's health improves sufficiently… an immediate transfer or discharge is required…, or a	Full	This requirement is addressed in the Medical Management – Member- Provider Notification of Initial Determinations on page 5.	

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**
	Member has not resided in the nursing facility…was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 8.			
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.	Full-2014			
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	Substantial - The Medical Management Medical Necessity Determination Policy addresses the ability of the member or provider to request an extension of up to 14	Full	Includes UM file review results 10 of 10 files met the timeliness standard. This requirement is addressed in the Medical	

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**
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.	days. The policy states that non-emergent decisions will be determined within two (2) business days consistent with the State Contract requirement. In regard to non-urgent decisions, there is no mention of the decision being made as expeditiously as the member's health condition requires. During the onsite review, Humana Care Source provided a revised draft version of the Medical Management Medical Necessity Determination Policy for review. The revisions are pending approval. <u>Recommendation for Humana CareSource</u> The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section D.		Management - Medical Necessity Determination Policy on page 4.	
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe	Substantial - The Medical Management Medical Necessity Determination Policy states,	Full	Includes UM file review results This requirement is addressed in the Medical	

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**
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 expires.	"Requests for prospective medical or behavioral health reviews may be extended one time for up to 14 calendar days provided that an extension is requested by the member or provider and is necessary because of matters beyond the control of the Plan. Notice is given in writing to the member, prior to the expiration of the initial 14 calendar day period of the circumstances requiring the extension and the date when the decision is expected to be made and of the right to file a grievance if he or she disagrees with the Plan's decision to grant an extension." However, this does not address the plan carrying out the determination as expeditiously as the member's health condition requires. During the onsite review, Humana CareSource provided a revised draft version of the Medical Management Medical Necessity Determination Policy for review. The revisions are pending approval. **<u>Recommendation for Humana CareSource</u>** The policy revisions should be approved and implemented.		Management - Medical Necessity Determination Policy on page 4.	

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**
	MCO Response: Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section D.			
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.	Substantial - The Medical Management Medical Necessity Determination Policy states, "Kentucky Prospective (Pre-service) Decisions 1. Prospective review of urgent medical or behavioral health care requests in which a Provider indicates or CareSource determines that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function no later than 72 hours (3 calendar days) of receipt of request or as expeditiously as the member's condition warrants." This indicates 3 calendar days, rather than 2 working days after receipt of the request. During the onsite review, Humana CareSource provided a revised draft version of the Medical Management	Full	This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 4.	

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**
	Medical Necessity Determination Policy for review. The policy revisions are pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section E.			
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.	Substantial - Timeframes for determinations are addressed in the Medical Management Member-Provider Notification of Initial Determinations policy and the Medical Management Medical Necessity Determination Policy. Issuance of notice on the date that timeframes expire is not addressed in either policy. During the onsite visit, Humana CareSource presented a revised drafted Medical Management Medical Necessity Determination Policy that includes the following: "Notice will be given on the date	Full	This requirement is addressed in the Medical Management - Medical Necessity Determination Policy on page 4.	

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**
	that the timeframes expire when service authorization decisions are 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." The policy revisions are pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented. **MCO Response:** Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section F.			

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	17	0	1	0
Total Points	51	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		**2.89**		

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

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report
Provider Satisfaction Survey Report

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
36. Program Integrity	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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 L, 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-2014			

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**
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2014			
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2014			
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;	Full-2014			
D. Effective lines of communication between the compliance officer and the organization's employees;	Full-2014			
E. Enforcement of standards through disciplinary guidelines;	Full-2014			
F. Provision for internal monitoring and auditing of the member and provider;	Full-2014			
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2014			
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-2014			
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2014			

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**
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-2014			
K. Contractor shall provide procedures for appeal process;	Full-2014			
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-2014			
M. Contractor shall create a process for card sharing cases;	Full-2014			
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-2014		Includes review of MCO Report # 75 SUR Algorithms	
O. Contractor shall follow cases from the time they are opened until they are closed; and	Full-2014			
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-2014			
The plan shall be made available to the Department for review and approval.	Full-2014			
9.1 Administration/Staffing				

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 member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract 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-2014			
Q, 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-2014			
37.15 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		Includes review of individual disclosures	

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:				
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		Includes review of individual disclosures	
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		Includes review of individual disclosures	
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-2014		Includes review of individual disclosures	
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-2014		Includes review of individual disclosures	
E. The identity of any person who has an ownership	Full-2014		Includes review of individual disclosures	

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**
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;				
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Full-2014		Includes review of individual disclosures	
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-2014			
State Contract, Appendix L				
ORGANIZATION: The Contractor's 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-2014			

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. Written policies, procedures, and standards of conduct that demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;	Full-2014			
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-2014			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2014			
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:	Full-2014			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full-2014			
(2) High dollar amount of potential overpayment; or	Full-2014			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full-2014			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2014			
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-2014			

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**
FUNCTION: Contractor/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-2014			
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Full-2014			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2014			
D. Initiate appropriate administrative actions to collect overpayments;	Full-2014			
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-2014			
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-2014			
G. Make and receive recommendations to enhance	Full-2014			

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 ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;				
H. Provide for prompt response to detected offenses and for the development of corrective action initiatives relating to the Contractor's contract;	Full-2014			
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			
J. Be subject to on-site review and fully comply with requests from the Department to supply documentation and records; and	Full-2014			
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-2014		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
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;	New Requirement	Full	This requirement is addressed in the Fraud Waste and Abuse Policy on page 8.	
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-2014			
N. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results	Full-2014			

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**
of their work to the Department;				
O. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Full-2014			
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-2014			
Q. Designate a contact person to work with investigators and attorneys from the Department and OIG;	Full-2014			
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-2014			
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-2014		Includes review of MCO Report #73 Explanation of Member Benefits (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-2014		Includes review of MCO Report #75 SUR Algorithms	
U .Collect administratively from Members for	Full-2014			

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**
overpayments that were declined prosecution for Medicaid Program Violations (MPV);				
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-2014			
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			
X. Recover overpayments from providers and identify Providers for pre-payment review as a result of the Provider's activities;	Full-2014			
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Full-2014			
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 agent thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.	Full-2014			
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	Full-2014			

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 Department and OIG.				
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:				
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-2014			
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-2014			
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-2014			
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-2014			
E. OIG will review the referral and attached documentation, make a determination and notify the PIU as to whether OIG will investigate the case or	Full-2014			

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**
return it to the PIU for appropriate administrative action;				
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 received from the OIG;	Full-2014			
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	Full-2014			

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**
pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
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			
(1) Name and address of subject,	Full-2014		Includes Program Integrity file review results	
(2) Medicaid identification number,	Full-2014		Includes Program Integrity file review results	
(3) Source of complaint,	Full-2014		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Full-2014		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Full-2014		Includes Program Integrity file review results	
(6) Name of investigator,	Full-2014		Includes Program Integrity file review results	
(7) Date of completion,	Full-2014		Includes Program Integrity file review results	
(8) Methodology used during investigation,	Full-2014		Includes Program Integrity file review results	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full-2014		Includes Program Integrity file review results	
(10) Attach all exhibits or supporting documentation,	Full-2014		Includes Program Integrity file review results	
(11) Include recommendations as considered necessary, for administrative action or policy revision,	Full-2014		Includes Program Integrity file review results	
(12) Identify overpayment, if any, and recommendation concerning collection,	Full-2014		Includes Program Integrity file review results	
(13) Any other elements identified by CMS for fraud	New Requirement	Non-Compliance	This requirement is not addressed in the	Humana - CareSource agrees with 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**
referral;			submitted documentation.	recommendation and has subsequently edited our policy to include all of the elements identified by NBI Medic in the Medicare Managed Care Manual, Chapter 21, section 50.7.5. This policy is set to go through Committee for review and approval on May 28th.
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-2014		Includes review of MCO Report #76Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
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-2014			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2014			
REPORTING: The Contractor's PIU shall report on a quarterly basis in a narrative report format all activities and 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	Full-2014		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**
suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.				
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-2014		Includes review of MCO Report #76 and Report #77	
(1) PIU Case number;	Full-2014		Includes review of MCO Report #76 and Report #77	
(2) OIG Case number if one has been assigned;	Not Applicable - Humana CareSource provided as evidence for this requirement the SIU Process Flow chart. The DMS report templates do not include OIG Case number. <u>Program Integrity File Review</u> None of the 3 files warranted an OIG Case number. **<u>Recommendation for DMS</u>** DMS should consider revising the report templates for reports 76 and 77 to include the OIG case number.		Includes review of MCO Report #76 and Report #77	
(3) Provider/Member name;	Full-2014		Includes review of MCO Report #76 and Report #77	
(4) Provider/Member number;	Full-2014		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**
(5) Date complaint received by Contractor;	Full-2014		Includes review of MCO Report #76 and Report #77	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2014		Includes review of MCO Report #76 and Report #77	
(7) Date opened and name of PIU investigator assigned;	Full-2014		Includes review of MCO Report #76 and Report #77	
(8) Summary of complaint;	Full-2014		Includes review of MCO Report #76 and Report #77	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	Not Applicable - Humana CareSource provided as evidence for this requirement the SIU Process Flow chart. The DMS template reports for Reports 76 and 77 do not include this requirement. **Recommendation for DMS** DMS should consider revising the report templates for reports 76 and 77 to include this requirement.		Includes review of MCO Report #76 and Report #77	
(10) PIU action taken and date (only provide the most current update);	Full-2014		Includes review of MCO Report #76 and Report #77	
(11) Amount of overpayment (if any) and time span;	Full-2014		Includes review of MCO Report #76 and Report #77	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2014		Includes review of MCO Report #76 and Report #77	
(13) The overpayment required to be repaid and overpayment collected to date;	Full-2014		Includes review of MCO Report #76 and Report #77	
(14) Describe sanctions/withholds applied to	Full-2014		Includes review of MCO Report #76 and	

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**
Providers/Members, if any;			Report #77	
(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;	Substantial - P/P CL-08 Claims – Provider Appeal: Ohio and Kentucky addresses, in general, the provider's claims appeal process but does not make reference to appeals related to FWA/SIU overpayments. For Members, addressed in P/P FW-05 and P/P SO-19 Service Operations – Member Appeal – Kentucky addresses the appeal process for members. For Providers and members, addressed in P/P FW-05, page 9, item # 11 Correction, which describes provider corrective action, termination and claims dollar recovery and the appeal process related to FWA/SIU, specifically, the SIU Corrective Action Appeals/Dispute Process and SIU Grievance and Appeal Process (KY only). Also addressed in the Provider Manual, section on FWA, under Corrective Actions. **Recommendation for Humana CareSource** In general, the combination of OH and KY requirements in the single P/P (CL-08 and FW-05) is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this (CL-08 and FW-05) and other MCO procedures and processes.	Full	This requirement is addressed in the Fraud Waste and Abuse Policy as well as in 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**
	MCO Response: Humana - Caresource agrees with the recommendation and will establish KY Medicaid specific FWA/SIU policies to ensure all KY requirements are addressed.			
(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-2014		Includes review of MCO Report #76 and Report #77	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2014		Includes review of MCO Report #76 and Report #77	
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-2014			
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2014			
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2014			

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. 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-2014			
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2014			
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Not Applicable - (NOTE: This has been deferred by DMS)			
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-2014			
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-2014			

Final Findings

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	0	0	1
Total Points	6	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		**2.0**		

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

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
Monthly state reporting
Quarterly Program Integrity Reports

File Review

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
32.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			Humana-CareSource indicated that for Kentucky Medicaid Policies and Procedures will be revised to be co-branded. This will be limited to Kentucky Medicaid and will not include corporate policies affecting all lines of business (e.g. human resources policies). Since the co-branding is not a material change to Policies and Procedures affecting the services offered to members or treatment of providers, the annual schedule of review will be utilized to implement these internal revisions.
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 J. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Substantial - The Member Handbook, the Provider Manual, description of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program on the Humana CareSource website, Provider Orientation within the Provider Portal Training, and the Winter Provider Newsletter all indicate that Humana CareSource members from birth up to 21 years of age are automatically eligible for EPSDT services. The	Substantial	Includes review of MCO Report #93 EPSDT CMS-416 Addressed in the Member Handbook on pages 18-19 and in detail, on pages 23-24; Provider Manual in detail, on pages 50-54; in the EPSDT Clinical Guidelines (American Academy of Pediatrics (AAP) and Medicaid EPSDT benefits, periodicity schedule) posted on the provider webpage; and in a variety of member education fliers, postcards and brochures for babies, children and adolescents.	Humana - CareSource agrees with the recommendation given that the two member communications (HUCS00791 Member Appeal Denial Letter and the HUCS00791 Member Appeal Denial Letter) were not approved for use during the 2014 contract year. The notices are now in effect with the correct language and the draft was provided to the IPRO team during the audit. The notices were pending KDMS approval at the time of the audit. We received KDMS approval on 3/31/2015

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**
	web orientation slides on the Provider Portal state that eligibility begins on the first day of the calendar month. Teens First and Children First Member Brochures also indicate EPSDT services are available from birth up to 21 years of age. The plan is new to the KY Medicaid program in 2013 and will submit its first annual CMS Form 416 on March 15, 2014. Report 24 provides an overview of EPSDT activities from 10/1/13 to 12/31/13, which indicates: outreach was performed to members in need of EPSDT screenings, the start of Provider Clinical Engagement Initiative, the enhancement of care management coordination services and the kick-off of Babies First Program as an incentive to reach members from birth to 15 months of age. Recommended screenings and components of age appropriate screenings are documented in the Provider Manual. Report 23 indicates that clinical practice guidelines are also posted on		Evidenced in quarterly Report #24 which describes activities related to EPSDT (e.g., member outreach) conducted each quarter. Humana submitted its first Report #93 EPSDT CMS-416 on March 15, 2014. Key Findings include: Screening ratio = 70.05% Range = 23.8% (19-20 yrs) to 100% (<1 and 1-2 yrs) Participation Ratio = 50.22% Range = 19.70% (19-20 yrs) to 100% (< 1 yr) Dental Services Any Dental = 34.29% Preventive = 31.68% Treatment = 13.64% Sealants = 9.44% (only ages 6-9 and 10-14 yrs) Diagnostic = 32.69% Oral Health Services by Non-dentist = 0.83% Any dental or oral health service = 34.73% The prior year file review revealed that the appeal resolution notices did not contain the possibility of member liability for payment for benefits received if the SFH finds in favor of the managed care organization (MCO). <u>EPSDT Appeal File Review Results</u> 5 of 5 EPSDT appeal files were compliant with standards except the inclusion of the possibility of member liability if a SFH finds in favor of the MCO.	In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe. In regards to the recommendation to address improvement areas identified in the CMS-416 report, Humana - CareSource does not agree with this finding as we have been fully compliant with this contract requirement. Humana – CareSource Program Description (PD) outlines our efforts to outreach to members. These efforts are guided by identification of who is in need of any component of EPSDT screening. We do not believe that targeting certain areas of the CMS – 416 improves outcomes and believe we should target all areas as outlined in the program description. These efforts include all components of the CMS-416. (well-child, dental/oral health, and lead screens, as well as treatment related to any findings) This is outlined on page 4 and 5 of the EPSDT Program Description provided to the IPRO prior to their on-site review. As outlined on page 5, the care management team communicates with members and their families who are eligible for EPSDT

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 Links page of the Member Portal. These guidelines include the periodicity schedule on American Academy of Pediatrics (AAP) website and the EPSDT overview on the CMS EPSDT website. The Clinical Practice Registry (CPR), described in the Member Identification Tracking Tools document, Preventive Health EPSDT and Individuals with Special Health Care Needs (ISHCN), Well Child screenshot, and Report 24, shows providers actionable preventive health services data by listing claims for PCP visits and preventive health related services. The CPR report is a 16 month go-live deliverable. Also closely related to the CPR is the Member Profile which tracks services delivered to members. In the second operational year for the plan, this report will be enhanced with HEDIS measure-based alerts so providers may identify members' needs. Providers have access to these reports, which are updated monthly on the Provider Portal. Care management, provider relations, and HEDIS staff use		Humana shared draft Policies and Procedures: HUCS00791 Member Appeal Denial Letter with Specialist Draft v3 2-9-2015 and HUCS00792 Appeal Denial without Specialist Draft v5 2-9-2015. The MCO indicated that as of the date of the onsite review, the policies were pending DMS approval. **Recommendation for Humana** The MCO should implement the new policies once approved by DMS. The MCO should include a statement regarding the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan in its appeal resolution notices. Humana should make targeted efforts to address areas where the CMS-416 report reveals that improvement is needed. **Final Review Determination** The substantial rating was due to the following: Policy and Procedure not in place at time of the Review. The following statement "regarding the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan" in its appeal resolution notice was not included.	services 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. These services include: • Immunization-related diseases (diphtheria, tetanus, pertussis, mumps, measles, rubella, hepatitis, pneumonia, polio, influenza, varicella); • Metabolic diseases (thyroid, hemoglobinopathies, PKU, galactosemia); • Dental caries, tooth decay, resulting dental complications; • Vision conditions; • Hearing conditions; • Complications related to childhood obesity; • Developmental disabilities; • Lead toxicity and related complications; • Sexually transmitted diseases; • Complications related to hypertension; • Complications related to hyperlipidemia; and • Conditions/complications from lack of guidance/education: Accidental injuries, Violence-related injuries, Nutritional deficiencies Page 4 of the EPSDT PD indicates: The EPSDT Coordinator coordinates and arranges for the provision of EPSDT services and EPSDT special services for members who have been identified as due EPSDT screens. The EPSDT Coordinator arranges for and assists with scheduling of provider

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**
	these reports also for provider outreach and education. The CMS-416 Annual EPSDT Participation Reports was provided onsite. This report was recently submitted to DMS and is the first annual report for the MCO. The report shows a total screening rate of 78% and a participant rate of 49%. UM File Review Five UM files related to EPSDT (child members) were reviewed. All files were completed timely and were compliant. Member Appeal File Review Five appeal files related to EPSDT (child members) were reviewed. Files were completed timely but did not address member liability for payment. **Recommendation for Humana CareSource** Appeal resolution notice should include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. It may be helpful for the plan to			visits for EPSDT services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years. A listing of members with screens due is prepared monthly and the EPSDT Coordinator provides outreach to the members to assist with scheduling of appointments as necessary. Using the member profile tool and alerts, clinical staff engages members at the point of contact to provide information about well-child care and immunizations. Using the Clinical Practice Registry, Humana CareSource staff partners with providers to identify members in need of EPSDT/well-child care. **DMS Response** If this requirement does not receive a Full in 2016, a lower score will be reflected.

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**
	develop a separate EPSDT program description that describes the numerous activities and initiatives involved including, but not limited to, the goals and objectives of the program, the provider responsibilities, member eligibility, the periodicity schedule, Immunization schedule, referral process and coverage of services, care management resources, outreach process, claims/billing, and EPSDT provider tools. This resource document could be used to provide a formal training for care managers, EPSDT Coordinator, and providers. The above recommendation was discussed with the MCO during the onsite review and MCO staff reported that they are already considering developing such a document. **MCO Response:** Appeal resolution notice will be updated to include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. HCS has developed a draft EPSDT Program Description as discussed			

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**
	during the annual review audit.			
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Full-2014			
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			
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-2014			
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		Includes file review results for EPSDT UM files and EPSDT Appeal files	
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 J.	Full-2014			
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary	Substantial - The Provider Manual states that routine care	Full	Addressed in the Provider Manual on pages 58-62 and in Policy and Procedure PR-01	

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**
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.	must be provided within 30 days of the members request and suggests that the EPSDT form be used to ensure compliance. Care must be provided in a culturally and linguistically competent manner and members must be treated with respect. PCPs must provide phone coverage afterhours; maintain an up to date medical record; and keep the members contact information accurate and current. Provider Site visits confirm office hours, after hours and wheelchair accessibility, use of web-access data, receipt of provider manual, and compliance with the periodicity schedule of EPSDT exams. Education on the periodicity schedule is provided. An office representative must acknowledge these elements were covered during the plan's visit. The Provider Representative must also sign the checklist. The plan provided a sample completed form (Provider Site Visit Form). The site visit is practice-specific and does not		Provider Relations - Provider Medical Record Standards, Privacy and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Assessment. Evidenced in the 2014 review of provider compliance with the EPSDT services periodicity schedule conducted by Altegra. Humana submitted the Altegra Executive Summary Report that provides results for the review of compliance with guidelines for HEDIS Adolescent Well Care Visits. Of the 40 charts reviewed, 82.5% had documentation of a preventive care/EPSDT visit. Non-compliance issues were related to general medical record documentation requirements. The QI Department is working with the Provider Relations to address the opportunities identified by the results. Additionally, the MCO indicated that the following EPSDT-focused HEDIS measures are evaluated: Well Visits in the First 15 Months of Life, Well Visits in the 3rd, 4th, 5th and 6th Years of Life, Childhood Immunization Status, Lead Screening in Children and via the Healthy Kentuckians Performance Measures: Adolescent Risk Screening and Counseling, Access to Care and Preventive Care for Individuals with Special Health Care Needs. The MCO indicated that since 2013 was the first reporting year for HEDIS and Healthy	

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**
	include review of member-specific medical records for EPSDT services. Per Humana CareSource, every 3 years the MCO will monitor compliance with clinical practice guidelines. In 2014, Humana CareSource will begin measuring compliance with primary care clinical practice guidelines including preventive guidelines for EPSDT. This process will begin after completion of HEDIS data collection (Spring 2014). **Recommendation for Humana CareSource** Humana CareSource should proceed with monitoring primary care records to assess compliance with the Department's periodicity schedule and EPSDT requirements. **MCO Response:** Humana CareSource disagrees with this determination. Humana CareSource is conducting this review during 2014. This compliance with clinical practice guidelines record review will measure adolescent prevention		Kentuckians (HK) Health Outcomes Performance Measures and the membership and service area expanded greatly in 2014, it is difficult to assess performance or trends in performance at this time. The upcoming measurement year 2014 results will be viewed as a baseline. The Provider Relations Department conducts annual provider office site visits during which compliance with the EPSDT periodicity schedule is assessed and education is provided. **Recommendation for Humana** Once sufficient data are available, Humana should consider developing and disseminating provider performance profiles for provision of EPSDT services.	

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**
	CPG (EPSDT visit requirements) ages 13 up to 21st birthday and is in compliance with the contract requirement. Final Review Determination: No change in compliance level. The review for Provider Compliance with EPSDT guidelines is planned for 2014. The period of review is CY 2013. Although Humana-CareSource's stated procedure for Provider Site visits includes confirming compliance with the periodicity schedule of EPSDT exams and education on the periodicity schedule. The Provider Visit Form/checklist did not include evidence of a review of records to confirm provision of EPSDT services.			
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-2014			
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for	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**
these services. Current requirements for EPSDT Special Services are included in Appendix J.				
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-2014			
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-2014			
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-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**
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-2014			
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.	Full-2014			
K. Participate in any state or federally required chart audit or quality assurance study.	Full-2014			
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 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.	Full-2014			
M. Submit Encounter Record for each EPSDT service provided	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**
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.				
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Full-2014			
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.	Full-2014			
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record 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-2014		Includes review of MCO Report #93 EPSDT CMS-416	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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	1	1	0	0
Total Points	3	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		**2.5**		

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

File Review

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

Reports

EPSDT reports (quarterly and annual 416 reports)
Annual EPSDT report of EPSDT activities, utilization and services

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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. Definitions	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.		Humana Care-Source addressed this general recommendation during the onsite review. The MCO indicated that the co-branding is to appear on all Kentucky Medicaid-specific policies and documents. The co-branding will not appear on general corporate-level policies and documents such as human resources policies.	
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				

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**
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, 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				

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**
team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, 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-2014			
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-2014		Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results)	
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-2014			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full-2014			
34.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Full-2014			
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				

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**
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-2014			
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs 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 with the Primary Care Provider's clinical treatment plan and medical diagnosis.	Full-2014			
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-2014		Includes file review results for Care Coordination and Complex Case Management	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Substantial - Addressed in P/P CM 22. <u>Care Coordination File Review</u> 10 out of 10 cases reviewed included a care plan. 10 out of 10 files reviewed included	Full	Includes file review results for Care Coordination and Complex Case Management Addressed in Policy and Procedure CM-21 Case Management – Care 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**
	identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family, as appropriate. Complex Case Management File Review 10 out of 10 cases reviewed included a care plan. 9 out of 10 files reviewed included identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family, as appropriate. **Recommendation for Humana CareSource** Case management files should demonstrate coordination of services with all service providers, member and family, as needed. **MCO Response:** Identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family, as appropriate, will be added		Policy and Procedure – Kentucky, in Section E, Procedure #5 Care Treatment Plans, on page 6, which discusses identification, assessment, development of care plans and care coordination for members enrolled in Case Management. Care Coordination File Review Results 10 of 10 files were compliant. Complex Care Management File Review Results 10 of 10 files were compliant. October, November and December 2014 results from internal reviews of case management (CM) files for identification of physical health (PH) and behavioral health (BH) needs and facilitation and coordination of services with all service providers, member and family were provided to demonstrate that the MCO addressed the lack of these items in the 2014 file review. The current file review demonstrated that all care coordination and complex care management files were compliant for all elements, including identification of PH and BH needs and facilitation and coordination of services with all service providers, member and family.	

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**
	to the internal quality auditing process for case management files.			
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 indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Minimal - P/P CM 22. 2013 Kentucky Care Management Model discusses program evaluation utilizing tools such as member surveys, SF-12 survey and outcomes based quality and utilization indicators. The program is reviewed annually and as needed. A summary report is posted to the provider's website. A Quality Improvement Work Plan is created annually and submitted in writing for review and approval prior to implementing any changes to the program. These activities are described for the overall care management population, not specifically for the Department of Community Based Services (DCBS) population. Utilization reports provided include inpatient and outpatient medical management key statistics for the Temporary Aid to Needy Families (TANF) and Aged, Blind and Disabled (ABD) populations. A draft quality measures report includes HEDIS measures with a breakout for children with special health care	Substantial	Addressed in Policy and Procedure CM-38 Case Management – DCBS Population Reporting, Analysis and Follow-ups. Evidence of tracking and reporting indicators related to utilization, access, complaints and grievances and services specific to the DCBS population was seen in the following reports: Utilization: MM Key Stats Foster Care, Access – MM Key Stats for Foster Care, and Complaints and Grievances, 2014 Grievances Foster DCBS. No report to address services specific to the DCBS population was found. The only evidence of analysis and actions taken when indicated was seen in the January 2015 Quality Assurance Committee (QAC) meeting minutes. The utilization report was presented to the committee. The June 2014 QAC meeting minutes included discussion of care for enrollees with special health care needs. **<u>Recommendation for Humana</u>** To more fully assess access to care, Humana should add metrics related to EPSDT services, well care visits, PCP visits, and ED	"Humana - CareSource agrees with the recommendation: Humana- CareSource will develop quarterly reporting of standard Grievance and Appeal and Utilization Management patterns. Including UM metrics such as -Inpatient, Readmission and Outpatient for all members 0-18. This data will then provide further analysis of the Members based on the population mix (TANF, ABD, DCBS). The data will be used to identify trends and possible opportunities for improvement. "

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**
	needs. Reporting for access, complaints and grievances, and satisfaction for this population was not provided. **Recommendation for Humana CareSource** The MCO should establish policies/procedures for tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population. Evidence of reporting, analysis and follow-up should be included for EQRO review. **MCO Response:** Humana CareSource will develop a policy and procedure addressing tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population.		utilization and compare per rates per 1,000 members or 1,000 member months (MM) with the rest of the population in same age group(s). For utilization, comparisons to the rest of membership of the same age should be done, if feasible. For grievances and appeals, might analyze for top categories to assess for patterns, if feasible. The MCO needs to demonstrate analysis, conclusions and actions taken where warranted for all indicators. When the number of members is large enough, the MCO should stratify its HEDIS rates by eligibility and age to assess for possible disparities for DCBS and DAIL clients. Once sufficient data are available, Humana should trend the results to identify if improvement occurs where needed.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full-2014			

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**
35.1 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-2014			
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-2014			
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-2014			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption	Full-2014		Includes review of MCO Report #20 Utilization of Subpopulations and ISCHN (see Quarterly Desk Audit results)	

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**
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.				
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-2014			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2014			
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-2014			
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-2014			
35.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster	Substantial - Addressed in P/P CM 21	Substantial	Includes review results for DCBS Service	Humana - CareSource agrees with 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**
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.	and P/P CM-22. Document titled "DCBS - Satisfaction Data for DCBS Population" indicates that the Meyers Group will conduct annual member satisfactions surveys. This process has not yet been completed, but is slated to be administered to the population in 2014. Document titled "Service Plans - Service Plans for DCBS and Department for Aging and Independent Living (DAIL) Members" states that the CM reviews and collaborates with the team on all services plans at a minimum of monthly and when changes in the plan occur. At this time, the Case Management documentation system Clinical Care Advance (CCA) team is identifying these members by case type for case manager dashboard upgrade. This will allow reports to be initiated on all DCBS/DAIL members indicating the presence of service plans, dates of review and triggers for future review dates. The estimated completion date is Q1 2014. <u>DCBS Service Plan File Review</u>		Plans and DCBS Claims/Case Management files. Addressed in Policy and Procedure CM-22 Case and Disease Management – Individuals with Special Health Care Needs (ISHCN) – KY and in Policy and Procedure CM-21 Case Management – Care Management Policy and Procedure – Kentucky, which describe the case management process including individuals with special health care needs ISHCN population; however, neither specifically mentions Service Plans for DCBS and DAIL clients. Addressed in Policy and Procedure CM-38 Case Management – DCBS Population Reporting, Analysis and Follow-ups, which describes the provision of care coordination for all DCBS and DAIL clients and mentions collaboration with DCBS and use of the DCBS Service Plan. Humana has a tracking system for Service Plans and a sample report was provided. The MCO also provided the document, Master Service Plan CCA (Care Advance CM system) Update Instructions/Project Lite Consolidated Entry Document, which describes an initiative being developed/piloted by Humana which will allow DCBS workers to upload the Service	recommendation: Humana – CareSource will draft a policy and procedure specifically for the care management of the DCBS population which will include the following IPRO suggested language, "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."

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
	20 out of the 20 files included ongoing care coordination to ensure access to needed social, community, medical and behavioral health services. DCBS Claims File Review 10 files were reviewed. 8/10 files demonstrated evidence of well visits and EPSDT services. For the 2 files without such evidence, no evidence of outreach was provided. 5 files showed evidence of need for physical health/behavioral health coordination and the files demonstrated provision of this coordination. 10/10 files demonstrated evidence of coordination with other service providers. **Recommendation for Humana CareSource** Humana CareSource should conduct ensure that outreach to DCBS members in need of age-appropriate well visits and EPSDT services. **MCO Response:** As indicated at the time of the review, Humana-CareSource utilizes the member profile to identify all members,		Plan to a shared platform; allow MCO CMs to view the number of DCBS and DAIL clients assigned and the number with/without Service Plans; view individual members; and when the Service Plan review is due. Eventually, DCBS workers will be able to access information from the CCA for their assigned cases. Evidenced in list provided to DCBS with members in need of Service Plans, minutes of monthly meetings with DCBS demonstrating attempts to identify members' DCBS workers, contact information for DCBS workers, and to obtain Service Plans. Evidenced in file review, CM notations that member will be enrolled in care management for care coordination due to DCBS status. Evidenced in the monthly reports for foster and guardianship members, Reports #65 and 66. Results from file review demonstrate that no members were applicable for outreach related to EPSDT services. Upon discussion with DMS, review of Service Plans is not 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**
	including DCBS members with care gaps (including age-appropriate well visits and EPSDT Services). Additionally all members are mailed the child and teen EPSDT brochures. These were submitted as documentation for the initial review. (RR KY MMED-78 and 79). An additional outreach was added in 2014. The EPSDT Coordinator makes outbound calls to members who are due or delinquent in their age-appropriate well visits and EPSDT services, which includes the DCBS members. Final Review Determination: No change in compliance level. The finding is based on the file review for DCBS Claims: 8/10 files demonstrated evidence of well visits and EPSDT services. For the 2 files without services/visits, no evidence of outreach was provided. There was no evidence provided of the outreach described for the two cases mentioned. General outreach is not sufficient for the file review. Member-specific documentation must be provided.		DCBS Service Plan File Review Results 10 of 10 files were compliant. DCBS Claims File Review Results 10 of 10 files were compliant. **Recommendation for Humana** Although the process for DCBS Service Plans is well-developed and defined, Humana should add the following contract language to its Policies and Procedures CM-21, CM-22 and/or CM-38 - "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."	

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**
35.3 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			
35.4 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.	Substantial - Document titled "Service Plans - Service Plans for DCBS and DAIL Members" states that the CM reviews and collaborates with the team on all services plans at a minimum of monthly and when changes in the plan occur. At this time, the Case Management documentation system Clinical Care Advance (CCA) team is identifying these members by case type for case manager dashboard upgrade. This will allow reports to be initiated on all DCBS/DAIL members indicating the presence of service plans, dates of review and triggers for future review dates. The estimated completion date is Q1 2014. <u>DCBS Service Plan File Review</u>	~~Substantial~~ Not Applicable	Includes review results for DCBS Service Plans files The Policies and Procedures CM-21, CM-22 and CM-38 address Service Plans for DCBS clients. ~~; however~~, the ~~specific procedures, such as signatures of both MCO and DCBS and process to follow when the MCO and DCBS do not agree on the need for CM, are not addressed.~~ ~~As noted above, the MCO has a Service Plan tracking database and provided a sample report. Additionally, documents describing the CM system upgrades to be piloted were provided.~~ ~~Evidenced in DCBS meeting minutes.~~ Two separate monthly meetings are held with DCBS, one at which the leadership of	Humana-CareSource disagrees with this determination: Per email on 5/22 from Stephanie Bates of KDMS, regarding service plans and any contract compliance issues with MCOs and DCBS/DAIL members: There is not a place for the MCOs to sign on the 106B (service plan) for either DCBS or DAIL members. The MCO should not be penalized for this on compliance reviews. DCBS would have to alter their "master" form in order for MCOs to be compliant with the signature. Every month, all five MCOs meet with DCBS and DAIL. Service plans are a standing agenda item for those meetings. Every MCO requests missing service plans, monthly, during those meetings and at other times by directly contacting the caseworkers. During those meetings, MCOs regularly provider reports

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**
	17 out of 20 cases included a service plan. Of the 17 cases that did include a service plan, 16/17 cases indicated monthly meetings to identify, discuss, and resolve health care issues of the child. In one case, evidence of collaboration with DCBS was provided through October 2013 but then was not noted again until March 2014. **Recommendation for Humana CareSource** Humana should continue to outreach to DCBS for service plans for all DCBS members. Ongoing collaboration with DCBS should occur at least monthly as required. **MCO Response:** Humana-CareSource believes they are in full compliance with this contract requirement. Humana-CareSource continually outreaches to DCBS for service plans for all DCBS members and will continue to do so. Per the contract, each child in Foster Care shall have a service plan prepared by DCBS. As Humana-CareSource must rely on the DCBS MCO Regional Liaisons and Case Workers to forward completed service plans to Humana-CareSource,		both organizations meet and the other at which MCO CM staff meet with DCBS staff. The minutes demonstrated that the MCO follows up with DCBS on missing Service Plans (sample list provided), requests contact information for DCBS workers assigned to members, and clarifies the workers assigned to the members. It was noted that the percentage of Service Plans received by Humana-CareSource for 2014 was > 80% overall. Upon discussion with DMS, review of Service Plans is not applicable. DCBS Service Plan File Review Results 10 of 10 were compliant ~~**Recommendation for Humana**~~ ~~Humana should add to its Policies and Procedures the specific procedures relative to Service Plans the process to follow when DCBS and the MCO do not agree on the need for CM, as outlined in the contract.~~ ~~Humana should continue meeting with DCBS, following up for Service Plans, and implement its pilot upgrades to the CM system.~~ **Final Review Determination** After discussion with DMS, this requirement	as to how many members they have enrolled including statistics regarding 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**
	the MCO can only encourage the receipt and work with DCBS to request those not received. As Humana-CareSource indicated during this audit, during 2013 Humana-CareSource had monthly meetings with DCBS Central Office Staff. In some cases, meetings were held on a weekly basis if there was an extremely challenging DCBS member and the need for collaborative efforts between Humana-CareSource, DCBS, CRP, BHDID, and DMS were identified. As indicated during the review, the Humana-CareSource had also began having monthly meetings with the DCBS Regional Liaisons to facilitate the receipt of service plans from DCBS case workers, discuss any issues and to coordinate activities for the DCBS members. Humana-CareSource believes this meets the contract intent of monthly meetings, as in many cases there are multiple DCBS/MCO meetings in any given month. As service plans are a standing agenda item at the monthly meetings with DCBS, we believe we are actively pursuing the receipt of service plans and meeting this contract element fully.		is considered Not 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**
	Final Review Determination: No change in compliance level. The finding is based on the file review results. There was a gap in communication/collaboration from October 2013 through March 2014 for one case. Monthly meetings were not evident during this time.			
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	
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	Substantial - Addressed in P/P CM-21 and document titled "Service Plans". DCBS Service Plan File Review None of the files with a service plan included signatures of both DCBS and the contractor. Service plans included the name of the DCBS staff person but not a signature. **Recommendation for Humana CareSource**	~~Substantial~~ Not Applicable	The Policies and Procedures CM-21, CM-22 and CM-38 address Service Plans for DCBS clients. ~~however, the specific procedures, such as signatures of both MCO and DCBS and process to follow when the MCO and DCBS do not agree on the need for CM, are not addressed.~~ As noted above, the MCO has a Service Plan tracking database and provided a sample report. Additionally, documents describing upgrades to the CM system that will be	Humana-CareSource disagrees with this determination: Per email on 5/22 from Stephanie Bates of KDMS, regarding service plans and any contract compliance issues with MCOs and DCBS/DAIL members: There is not a place for the MCOs to sign on the 106B (service plan) for either DCBS or DAIL members. The MCO should not be penalized for this on compliance reviews. DCBS would have to alter their "master" form in order for MCOs to be compliant with the signature.

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**
through mediation, the service plan shall be referred to the Department for resolution through the appeals process.	Humana should continue to outreach to DCBS for service plans for all DCBS members and ensure signatures are completed, where possible. **MCO Response:** Humana-CareSource does not believe that minimal compliance is an accurate determination. Humana CareSource continually outreaches to DCBS for signatures and will continue to do so. However, DCBS revised the service plan in 2014 and the 2013 Foster Care Form is no longer in use by DCBS. Humana-CareSource was asked by DCBS to use a new revised DCBS Foster Care Form. This form does not have a place for a signature of the DCBS MCO Liaison or the Humana-CareSource Foster Care Liaison. Humana-CareSource has ask the MCO liaison's to please have their workers sign this form at the bottom and then once received by our Foster Care Liaison, the Liaison will sign it and scan it into our documentation system. The new DCBS form that Humana-CareSource further impedes Humana-Care Source's ability to obtain signatures.		piloted were provided. Evidenced in DCBS meeting minutes. Two separate monthly meetings are held with DCBS, one at which the leadership of both organizations meet and the other at which MCO CM staff meet with DCBS staff. The minutes demonstrated that the MCO follow-ups with DCBS on missing Service Plans (sample list provided), requests contact information for DCBS workers assigned to members, and clarifies the workers assigned to the members. It was noted that the percentage of Service Plans received by Humana for 2014 was > 80% overall. ~~Regarding Humana's statement in 2014 that there was a "new" Service Plan form that did not have a space for the MCO signature, during the file review, a Service Plan form other than the DPP-106-B was seen in a number of files. This form did not have a form number and did not contain a space for MCO signature. However, the MCO staff signed the forms below the DCBS signature. The source of the form is not known.~~ Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review (10)</u>	Every month, all five MCOs meet with DCBS and DAIL. Service plans are a standing agenda item for those meetings. Every MCO requests missing service plans, monthly, during those meetings and at other times by directly contacting the caseworkers. During those meetings, MCOs regularly provider reports as to how many members they have enrolled including statistics regarding 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**
	Final Review Determination: Substantial Compliance The finding is based on the file review results. No Service Plans reviewed had a signature; however, Humana CareSource makes a significant effort to obtain the Service Plans and DCBS signatures. DMS has requested that Humana-CareSource to clarify the issue of DCBS providing a new form. Please explain and provide a copy of the stated form. Per DMS's understanding, the current Service Plan form is Form 106-B.		10 of 10 were compliant. **Recommendation for Humana** ~~As noted in the prior element, Humana should update Policies and Procedures CM-21, CM-22 and/or CM-38 with the contract language related to Service Plans and CM for DCBS and DAIL clients ("The DCBS and designated Contractor staff will sign each Service Plan to indicate their agreement with the MCO. 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.")~~ ~~Humana should continue meeting with DCBS, following up for Service Plans, and implement its pilot upgrades to the CM system.~~	

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**
35.5 Children Receiving Adoption Assistance				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.	Full-2014			
32. 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.	Minimal - Not addressed in documents provided. Contractor stated during interview that they do have providers in network that have the capacity to perform a forensic pediatric sexual abuse examination upon request. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure that addresses this requirement. **MCO Response:** Prior to the on-site review, HUMANACARESOURCE provided a listing to the IPRO of in network providers who were qualified to do a forensic pediatric sexual abuse examination. This listing was titles "Pediatric Sexual Abuse Providers". The following listing was provided:	Full	Addressed in Policy and Procedure CM-37 Care Management and Disease Management – Forensic Pediatric Sexual Abuse Examination.	

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**
	Pediatric Sexual Abuse Providers Melissa Currie, M.D., division chief Kelli Marvin, Ph.D. Lisa Pfitzer, M.D. Andrea Taroli, M.D. Gina Bertocci, Ph.D. Based on the documentation provided to the IPRO prior to the visit, Humana-CareSource believes this element should be in full compliance as it meets the contract requirement, which states "Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination." There is no indication of a policy requirement related to this. <u>Final Review Determination:</u> No change in compliance level. IPRO checked all compliance documentation on its system, on the ftp site, and in hard copy and did not locate this list. Based on the recorded interview response, there is no change in the compliance level.			
32.8 Pediatric Interface				
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				

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**
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. Services 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.	Minimal - Policy/procedure addressing school-based services was not provided. During the interview, Contractor stated that during school breaks the Contractor is responsible for providing and coordinating all Medically Necessary Covered Services. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with schools and agencies that provide EI services and school-based services. **MCO Response:** Humana-CareSource will develop a policy and procedure addressing coordination with schools and agencies that provide EI services and school-based services.	Full	Addressed in Policy and Procedure CM-39 Case Management – Care Management Pediatric Interface and Early Intervention 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	New Requirement	Full	Addressed in Policy and Procedure CM-39 Case Management – Care Management Pediatric Interface and Early Intervention	

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**
conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.			Services.	
37.11 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-2014		Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results)	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

Final Findings

Case Management/Care Coordination/Department for Community Based Services (DCBS) Clients

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	2	0	0
Total Points	12	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		**2.67**		

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

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Monthly reports of Foster Care cases

File Review

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014– December 31, 2014
MCO: Humana-CareSource

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**
22.6 Member Rights and Responsibilities	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			Humana-CareSource indicated that for Kentucky Medicaid policies and procedures will be revised to be co-branded. This will be limited to Kentucky Medicaid and will not include corporate policies affecting all lines of business (e.g. human resources policies). Since the co-branding is not a material change to policies and procedures affecting the services offered to members or treatment of providers, the annual schedule of review will be utilized to implement these internal revisions.
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-2014			
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.	Full-2014			

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'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-2014			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full-2014			
C. Consent for or refusal of treatment and active participation in decision choices;	Full-2014			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full-2014			
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-2014			
F. Timely access to care that does not have any communication or physical access barriers;	Full-2014			
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full-2014			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full-2014			
I. Timely referral and access to medically indicated specialty care; and	Full-2014			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full-2014			

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 also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full-2014			
B. Abide by the Contractor's and Department's policies and procedures;	Full-2014			
C. Become informed about service and treatment options;	Full-2014			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full-2014			
E. Report suspected Fraud and Abuse; and	Full-2014			
F. Keep appointments or call to cancel.	Full-2014			
22.2 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-2014			
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.	Substantial - The Policy CM-10 states "that marketing and member materials are available in any language that is the primary language that meets the percentage threshold set for the geographic service area by the state or CMS."	Substantial	Addressed in CO-10 Marketing-Material Development for Non-English Speaking and Special Needs Populations. Evidenced in revised policy CM-10 Marketing - Material Development for Non-English Speaking and Special Needs Populations which now contains the 5%	**DMS Response** Since IPRO recommended that the policy be updated in the previous year also, an LOC /CAP maybe issued. Humana - CareSource agrees with the recommendation. Policy CO-10: Material Development for Non-English Speaking and Special Needs Populations has been revised to specify that

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**
	Recommendation for Humana Policy should be revised to specify that the KY percentage threshold is 5%. **MCO Response:** While the policy states that we will meet the plan specific requirements, Humana CareSource can add the threshold information to policy CO-10.		threshold for Kentucky Medicaid. The revised policy has been approved internally as of March 2015 and is pending final DMS approval. **Recommendation for Humana** The MCO should obtain approval from DMS for this requirement and add to the member handbook.	the KY percentage threshold is 5% and awaits KDMS approval. The Plan will act with a sense of urgency with deliverables such as these moving forward. 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. The Member Handbook includes information about getting printed materials in other languages or formats at no cost to them. For clarification purposes, the plan will implement any additional content changes (specific to the 5% threshold) if KDMS advises.
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full-2014			
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.	Substantial - Plan stated during interview they are currently in the process of approval of 2014 Member Handbook with state. Plan stated they do not currently have an annual revision policy for the Member Handbook, but stated that the Member Handbook is revised as needed. **Recommendation for Humana CareSource** A policy/procedure for updating the Member Handbook should be developed and include marking the Member Handbook with a version	Full	Addressed in CO-15 Marketing-Safeguarding Accuracy of Communications. Evidenced in the Member Handbook provided, which contains a KDMS file and use date of 6/19/2014 on the back cover and a 2014 copyright.	

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**
	date or revision date and obtaining DMS approval. **MCO Response:** Language will be added to an existing policy or a new policy will be created that states the member handbook will be reviewed/revised (as necessary) on an annual basis. A version date or revision date, along with the KDMS approval date will be included on the Member Handbook.			
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Full-2014			
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-2014			
B. The procedures for selecting a PCP and scheduling an initial health appointment;	Full-2014			
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;	Substantial - The Member Handbook contains the Contractor name, business telephone number, hours of business, the Member Services telephone number and the 24/7 toll-free medical call-in system. This requirement, with the exception of the Contractor's	Full	Addressed and evidenced in the revised Member Handbook on page 3, which contains the MCO address: 10200 Forest Green Boulevard, Suite 400 Louisville, KY 40223	

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**
	address, is found in the Member Handbook. **Recommendation for Humana CareSource** The MCO should include the address from which business is conducted in Member Handbook. **MCO Response:** The current version of the KY statewide member handbook (KY-MMED-532) includes our office address (page 3), whereas the version used for the IPRO audit did not.			
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 for those services authorized by the Contractor;	Full-2014			
E. Member rights and responsibilities including reporting suspected fraud and abuse;	Full-2014			
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-2014			
G. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full-2014			
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Full-2014			

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**
I. Procedures for arranging EPSDT for persons under the age of 21 years;	Full-2014			
J. Procedures for obtaining access to Long Term Care Services;	Full-2014			
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Minimal - Procedures for notifying the Department for Community Based Services (DCBS) are not found in the Member Handbook. DCBS is mentioned on page 5 – regarding the Kentucky Health Choices ID card and on page 29, regarding eligibility/loss of eligibility. Regarding family size changes, births are mentioned on page 5, but it states that the member should notify Humana CareSource to obtain and ID card for the baby. Address changes and death notifications were not found. **Recommendation for Humana CareSource** The Member Handbook should include information for members regarding contacting DCBS in the event of a birth, death or address change. **MCO Response:** The current version of the KY statewide member handbook (KY-MMED-532) includes our office address (see page 3),	Full	Addressed and evidenced in the revised Member Handbook on page 4, which includes procedures for notifying DCBS in the event of change in family size or address.	

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**
	whereas the version used for the IPRO audit did not. Page 4 of the current KY statewide member handbook (KY-MMED-532) includes information for members regarding contacting DCBS in the event of a birth, death or address change. Also, DCBS contact information is included on the inside back cover as well as KDMS and other important state-related contact information.			
L. A list of direct access services that may be accessed without the authorization of a PCP;	Full-2014			
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;	Full-2014			
N. Information about how to access care before a PCP is assigned or chosen;	Full-2014			
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;	Full-2014			
P. Procedures for obtaining Covered Services from non-network providers;	Full-2014			
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-2014			
R. Information about the Cabinet for Health and Family	Full-2014			

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**
Services' independent ombudsman program for Members;				
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Full-2014			
T. Information on the availability of health education services;	Full-2014			
U. Information deemed mandatory by the Department; and	Full-2014			
V. The availability of care coordination, case management and disease management provided by the Contractor.	Full-2014			
30.3 Second Opinions				
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, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Full-2014			
22.1 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	Full-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	

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**
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.				
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) 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).	Full-2014			
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-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
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	Full-2014			

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**
Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				
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-2014			
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Full-2014			
B. Monitoring the selection and assignment process of PCPs;	Full-2014			
C. Identifying, investigating, and resolving Member Grievances about health care services;	Full-2014			
D. Assisting Members with filing formal Appeals regarding plan determinations;	Full-2014			
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Full-2014			
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud	Full-2014			

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**
and abuse;				
G. 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-2014			
H. 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-2014			
I. Explaining or answering any questions regarding the Member Handbook;	Full-2014			
J. 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	Full-2014			

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**
termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;				
K. 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-2014			
L. 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-2014			
M. Providing Members with information or referring to 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;	Full-2014			
N. 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-	Full-2014			

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**
related conditions and other communicable diseases; all as further described in Appendix I of this Contract;				
O. Facilitating access to behavioral health services and pharmaceutical services;	Full-2014			
P. 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-2014			
Q. 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-2014			
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Full-2014			
S. 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-2014			
T. Facilitating access to Member Health Education Programs;	Full-2014			
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in **Covered Services** upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to	Full-2014			

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**
them including referral to case management or disease management; and				
V. 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-2014			
30.4 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.	Substantial - This requirement is found in Policy CM-02. The provision regarding a provider billing a member for a Medicaid Covered Service is addressed in the Provider Manual but does not specify the potential criminal charges. **Recommendation for Humana CareSource** The Provider Manual should specify the possible criminal charges if a member is billed for a Medicaid Covered Service. **MCO Response:** Humana CareSource will add the information regarding possible criminal charges for billing a member for a Medicaid Covered Service, to the Provider Manual.	Minimal	This is not addressed in the Provider Manual. The Member Billing Policy on page 14 in the 2013 provider manual does not contain a statement that any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act.. Humana-CareSource provided a draft revised Provider Manual dated 12-18-14. This manual addresses the federal requirement on page 11. Humana stated that the manual is currently in internal review and will be submitted to DMS for review and approval. Review determination is minimal because this is a Federal Regulation and the prior year's recommendation was not addressed.	Humana - CareSource agrees with the determination given that the updated Provider Handbook was not in use for the 2014 contract year. We continue to work with KDMS to obtain approval on this outstanding item. During a meeting with Wayne Dominick, KDMS, on 05/19/15, it was brought up that the 2014 Provider Manual has been with KDMS since December 2014 for review and approval. In order to prevent delays in approval of critical communications in the future, Humana-CareSource will collaborate with KDMS to establish a process for expected turnaround times and escalation steps to manage a more timely resolution timeframe.

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**
			Recommendation for Humana Humana-CareSource should complete the internal approval process and then submit the manual to DMS for review and approval.	
However, if a Member agrees in advance in writing to pay 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.	Full-2014			
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.	Full-2014			
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-2014			
23.4 PCP Changes				
The Contractor shall have written policies and procedures	Full-2014			

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 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.				
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-2014			
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 Contractor's Region.	Full-2014			
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 of the request.	Full-2014			
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	Full-2014			

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**
medical needs of the Member.				
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-2014			
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The Provider shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Full-2014			
30.5 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 Member for Non-Covered services that shall provide for the transition 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.	Full-2014			

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	3	1	1	0
Total Points	9	2	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		**2.4**		

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 providers
- 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
Medical call-in system metrics

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
22.3 Member Education and Outreach	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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-2014			

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**
Creative methods should be used to reach Contracor'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-2014			
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-2014			
22.4 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-2014			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-2014			
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-2014			

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**
22.5 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-2014			
be published in at least a 14-point font size, and	Full-2014			
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-2014			
Font size requirements shall not apply to Member Identification Cards.	Full-2014			
Braille and audiotapes shall be available for the partially blind and blind.	Full-2014			
Provisions to review written materials for the illiterate shall be available.	Full-2014			
Telecommunication devices for the deaf shall be available.	Full-2014			
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.	Full-2014			
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2014			
All written materials provided to Members, including forms used to notify Members of Contractor actions and	Full-2014			

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**
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.				
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 Developmental Health for approval prior to publication and distribution to Members.	New Requirement	Not Applicable	DMS has instructed Humana to submit materials to DMS and the State will submit to DBHDID as needed.	
28.12 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-2014			
The Contractor shall communicate such policies to Subcontractors.	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	***Only 1 element scored and is Not Applicable***			
Total Points				

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	***Not Applicable***			

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
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014

Final Findings

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**
38.1 Medical Records	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
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-2014			

Final Findings

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 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 of this Agreement.	Full-2014			.
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Substantial - The Humana 2014 KY Market Addendum Corporate Quality Improvement Program Description (QIPD) Medicaid Managed Care Program states that the Privacy Officer is responsible for implementing and auditing of policies. A document addressing conduct of audits as prescribed by the Department was not available. During provider site visits, provider representatives confirm that the provider office has HIPAA policies in place. Per Humana CareSource, the MCO's audit process of provider medical records is currently in development. The focus for 2014 will be primary care. **Recommendation for Humana CareSource** A policy/procedure should address conduct of audits of privacy practices prescribed by the Department. **MCO Response:** Humana-Care Source agrees with this recommendation. The Plan currently uses a site visit tool with a key that includes auditing the provider office and documentation of HIPAA	Full	This requirement is addressed in Provider Medical Record Standards, Privacy and Early Periodic Screening, Diagnosis and Treatment (EPSDT) assessment and completed examples of provider site visit forms.	

Final Findings

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**
	compliance. A policy and procedure will be developed regarding the tools and activities.			
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			
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-2014			
The Contractor shall develop methodologies for assessing performance/compliance to medical	Full-2014			

Final Findings

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**
record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:				
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;	Full-2014			
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full-2014			
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Full-2014			
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	Full-2014			
27.6/27.7 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,	Full-2014			

Final Findings

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**
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.				
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-2014			
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-2014			
A. Member/patient identification	Full-2014			

Final Findings

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**
information, on each page;				
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-2014			
C. Date of data entry and date of encounter;	Full-2014			
D. Provider identification by name;	Full-2014			
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-2014			
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-2014			
G. Identification of current problems;	Full-2014			
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;	Full-2014			

Final Findings

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**
I. Documentation of immunizations pursuant to 902 KAR 2:060;	Full-2014			
J. Identification and history of nicotine, alcohol use or substance abuse;	Full-2014			
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-2014			
L. Follow-up visits provided secondary to reports of emergency room care;	Full-2014			
M. Hospital discharge summaries;	Full-2014			
N. Advanced Medical Directives, for adults;	Full-2014			
O. All written denials of service and the reason for the denial; and	Full-2014			
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-2014			
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's	Full-2014			

Final Findings

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**
medical/behavioral health, including mental health, and substance abuse status;				
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-2014			
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-2014			
27.7/27.8 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 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.	Full-2014			
The Contractor shall, at a minimum,	Full-2014			

Final Findings

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**
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.				
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-2014			
38.2 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 40.12.	Full-2014			
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	Full-2014			

Final Findings

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**
assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.				
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-2014			
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-2014			
40.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the	Full-2014			

Final Findings

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**
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 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 is the Contractor.				

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014

Final Findings

Medical Records

Scoring Grid:

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

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
33.3 General Behavioral Health Requirements	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. MCO Response: Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.			
The Department requires the Contractor's provision of behavioral health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.	Full - 2014			
33.4 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 I.	Full-2014			
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the	Full-2014			

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**
DSM-V classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-V.				
Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record.	Full-2014			
33.5 Behavioral Health Provider Network				
The Contractor must emphasize access to services, utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.	Full-2014			
The Contractor shall utilize ICD-9/10 coding and DSM-V classification for Behavioral Health billings.	Full-2014			
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.	Full-2014			
Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	Full-2014			
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	Full-2014			

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**
continue to provide the same services they currently provide under their licenses.				
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full-2014			
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.	Full-2014			
The Contractor shall permit Members to participate in 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.	Full-2014			
33.6 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 Contractor's region.	Full-2014			
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full-2014			
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-2014			
It is not acceptable for an intake line to be answered by	Full-2014			

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**
an answering machine.				
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:	Substantial - Contractor submitted Hotline data for the months of February 2013 through December of 2013. The Hotline met or exceeded all of the minimum performance requirements for most months of the year with the exception of July 2013 – where one performance requirement was not met. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas. **MCO Response:** Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal	Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) See subcomponents below.	Humana - CareSource agrees with the recommendation. See responses in subcomponents below:

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**
	Corrective Action Plan (CAP).			
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Substantial - 100% of the calls were answered by the fourth ring for all months of the year evaluated. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas. **MCO Response:** Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) The Member Services and Clinical Referral and Triage Process Policy (UM 62.29) and Availability and Accessibility of Clinical Services Policy (QM 24.20) include language that 99% of calls received by Beacon will not receive a busy signal. Per MCO Report #11, the standard for answering calls on or before the 4th ring was met for Q1-Q4 in 2014.	
B. No incoming calls receive a busy signal;	Full-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit	

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**
			results)	
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;	Substantial - 100% of calls were answered within 30 seconds for most months of 2013, but in July 2013 only 75% were answered within 30 seconds. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas. **MCO Response:** Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) The Member Services and Clinical Referral and Triage Process Policy (UM 62.29) and Availability and Accessibility of Clinical Services Policy (QM 24.20) included language that Beacon telephone answering is measured against contract specific performance requirements such as percentage of calls answered within thirty (30) seconds or less. Per MCO Report #11, the standard for at least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds was met for Q1-Q4 in 2014.	
D. The call abandonment rate is seven percent (7%) or	Substantial - Call abandonment rate was 0% for	Substantial	Includes review of MCO Report #11 Call	Humana - CareSource agrees with the

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**
less;	all months evaluated. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas. **MCO Response:** Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).		Center (see Quarterly Desk Audit results) The Member Services and Clinical Referral and Triage Process Policy (UM 62.29) on page 5 and Availability and Accessibility of Clinical Services Policy (QM 24.20) on page 10 include language that Beacon telephone answering is measured against contract specific performance requirements such as percentage of calls abandoned. The MCO's call abandonment rate did not meet the requirement of 7% or less for all months in 2014. Per MCO Report #11, in August 2014, the abandonment rate for the Behavioral Health Hotline was 7.69% (1 call out of 14 received). Abandonment rates for all other months were 0%. The number of calls per month ranged from 5 to 27. **Recommendation for Humana** Humana should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all months.	recommendation regarding abandonment rate metrics performance. While only a single call was abandoned in the month of August 2014 in the Behavioral Health Hotline, our abandonment rate was 7.69% because we only received 14 calls. In fact, it was our only abandoned call for the entire year. Nevertheless, we exceeded the allowable abandonment rate for that month. We will diligently work to ensure that we have staffing in place to avoid missing this target in the future.
E. The average hold time is two (2) minutes or less; and	Substantial - Average hold time was under 2 minutes for all months evaluated. January 2013 Call Center report submitted by	Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	Humana - CareSource agrees with the finding and recommendation to include average hold time for Behavioral Health Hotline as a required metric for

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 contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas. **MCO Response:** Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).		The Member Services and Clinical Referral and Triage Process Policy (UM 62.29) on page 5 and Availability and Accessibility of Clinical Services Policy (QM 24.20) on page 10 include language that Beacon telephone answering is measured against contract specific performance requirements such as average hold time not to exceed two (2) minutes. MCO Report #11 shows average hold time not reported in any month for 2014. **Recommendation for Humana** The MCO should report average hold time as required.	measurement. Humana-CareSource will include this metric in the next reporting period for Report #11.
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-2014			
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.	Full-2014			
The Contractor cannot impose maximum call duration	Substantial - Contractor stated during the	Full	This requirement is addressed in Clinical	

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**
limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	interview that contractor does not impose maximum call duration limits and ensures calls are of sufficient length to provide adequate information to member. Evidence of imposing call duration limits was not found in the documents provided however; the report "HU_Reports_140102_Report11" shows the average length of call to be 3 minutes 3 seconds. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should include language that the MCO will not impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member in its P/Ps. **MCO Response:** Humana CareSource and Beacon will add this language in its SOPs.		Coverage and Access to Utilization Management Staff (UM 1.26) on page 1.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Full-2014			
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about	Minimal - Contractor stated during the interview that hotline staff is trained in the contractor programs and service areas, including provider networks.	Full	This requirement is addressed in the Member Services and Clinical Referral and Triage Process Policy (UM 62.29) and training materials such as the Humana CareSource Behavioral	

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**
all such Service Areas, including the Behavioral Health Provider Network in each Service Area.	No documentation of the contract-specific training content for Kentucky Medicaid was found. **Recommendation for Humana CareSource/BHS** Humana CareSource/BHS should include in its SOP and/or P/Ps and its hotline staff training documentation that the Behavioral Health Services Hotline may serve multiple Contractor Programs and service areas and that the Hotline staff is trained regarding all of the Contractor Programs, service areas and the Behavioral Health Provider Network in each Service Area. **MCO Response:** Humana CareSource disagrees with this finding. Beacon has a Humana CareSource specific SOP called a "training sheet" that includes the language that "the Behavioral Health Services Hotline may serve multiple Contractor Programs and service areas and that the Hotline staff is trained regarding all of the Contractor Programs, service areas and the Behavioral Health Provider Network in each Service Area." The "training sheet" was provided to auditors during the onsite interview. Final Review Determination: No change in compliance level. The SOP that lists the requirement for serving multiple programs is not sufficient evidence of compliance. Evidence of training relative to Kentucky-specific		Health/Substance Abuse Cheat Sheet. This cheat sheet explains who Beacon is and what services members can receive through Beacon, Beacon's phone number and website. The Cheat Sheet also clarifies which type of calls should be handled by Humana and which should be transferred to Beacon and provides regional crisis line phone numbers.	

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**
	programs and requirements is necessary to meet this element. For instance, the training materials used/provided to staff members that contain the Kentucky Medicaid material.			
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2014			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 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 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-2014			

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 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 screening techniques for PCPs and new models of behavioral health interventions.	Full-2014			
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 - Addressed in BHS P/P UM 230.01 Behavioral Health Treatment and Discharge Planning, BHS P/P UM 93.12 Collaboration and Referral of Medical and Behavioral Health Cases between Beacon Health Strategies and Partner MCO, BHS P/P QM 15.16 Exchange of Information Between Behavioral Health, Primary Care Providers and Behavioral Health Practitioners and BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process. Addressed in BHS and Humana CareSource Provider Manuals. <u>BH/PH Coordination File Review</u> ▪ 10 files were reviewed. ▪ 3 files were not applicable due to inability to enroll member in care coordination despite MCO attempts to engage member. ▪ 7 of 7 applicable files included a comprehensive assessment. ▪ 7 of 7 files included a care plan. ▪ 5 of 7 applicable files included adequate information sharing	Substantial	Includes BH/PH Care Coordination file review summary results This requirement is addressed in Continuity and Coordination between Medical Care and Behavioral Healthcare (QI-23), Exchange of Information Between Behavioral Health, Primary Care Providers and Behavioral Health Practitioners (QM 15.16) and Collaboration and Referral of Medical and Behavioral Health cases between Beacon Health Strategies and Partner MCO (UM 93.13). <u>BH/PH Coordination File Review Results</u> 10 files were reviewed. 5 of 10 files included a comprehensive assessment with the required components. The remaining 5 files were not applicable as the member was unreachable or refused services. 6 of 10 files included a care plan with	Humana - CareSource disagrees with the findings as we believe we have been fully compliant with this contract requirement as evidenced by: Per Beacon, the attached policy CM 1.14 (given to auditor at the review) fully explains that enrollment into ICM/CM services is inclusive of assisting family/member with resources: Case Management is defined as a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy to meet an individual's and family's comprehensive health needs through communication and the available resources to promote quality cost effective outcomes. (CMSA 2009) Beacon's Intensive Case Management (ICM) program, through collaboration with members, members' guardian, representative and/or family member (s), state agencies, schools, community providers and their treatment providers, is designed to ensure the

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**
	▪ 7 of 7 applicable files included monitoring of diagnosis, treatment, and follow-up and medication usage. ▪ 3 of 3 applicable files included case managers and other identified behavioral health service providers participating in discharge planning if the member was hospitalized (7 files were not applicable as member was not hospitalized.) ▪ 7 of 7 applicable files included identification of the physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family. **Recommendation for Humana CareSource/BHS** Files should contain documentation of information sharing between physical health and behavioral health providers. **MCO Response:** Humana CareSource is currently drafting a SOP which will outline the provider expectation for BH and PH file sharing.		the required components. The remaining 4 files were not applicable. 4 of 10 files included identification of the PH and BH needs of the member and facilitation and coordination of needed services; five files were not applicable. One member reported difficulty remembering her meds and paying prescription co-pays. It was noted that the member could benefit from medication reconciliation and there was no documentation of medication review or claims or follow up during the last conversation with the member. 2 of 10 files showed need for follow-up/rescheduling of missed appointments and follow-up was documented. 7 of 10 members were hospitalized and participation in discharge planning was evident in all files. 5 of 10 files evidenced information sharing, other than the initial referrals from/to behavioral health care management. 4 files were not applicable. Although the initial assessment for one member indicated that member had medical issues	coordination of care, including assessment, case management planning, discharge planning and mobilization of resources to facilitate an effective outcome for cases with high risk clinical factors and/or high utilization. Elders, adult and children at clinical risk because of the mental health, psychosocial and/or co-morbid problems are referred and reviewed to evaluate for potential impact through the Intensive Case Management program. The case manager works collaboratively with the member to advocate for and assist with linkage to necessary supports and services, including community resources, and to facilitate coordination with family and other involved parties. The CM notes shown to auditors and provided did show that the CM outreached the member's guardian for enrollment into the program which implies once enrolled a review of discharge planning would occur.

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
			requiring co-management, there was no documentation in the file showing communication between the behavioral health and medical care managers. **Recommendation for Humana** The MCO should address the following: Files should contain documentation of information sharing between physical health and behavioral health, and monitoring of diagnosis, treatment, and follow-up and medication usage. **Final Review Determination** No change in review determination. This finding was discussed with DMS. The review determination is based on the following file review findings (described in detail above): For one member, after a notation in the CM record that the member would benefit from medication reconciliation, there was no follow up action noted in the file. For a second member, although the assessment revealed medical issues, there was no evidence in the file of communication/coordination between the BH and PH care managers. Also, a description of 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**
			functions in a Policy and Procedure is not sufficient to demonstrate performing those functions. For the file reviews, there must be documentation in the care management record to achieve compliance. Implying actions were taken by virtue of a statement in Policy is not sufficient. Humana/Beacon should ensure that all care management actions are demonstrated and documented in the case file in order to achieve compliance for the file reviews. Upon the next review, IPRO will conduct a file review to evaluate same.	
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-2014			
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	Full-2014			

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**
or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.				
33.8 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-2014			
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full-2014			
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Full-2014			
33.9 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 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.	Full-2014			

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 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			
33.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
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 admitted to the state psychiatric hospital.	Full-2014			
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. 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.	Full-2014			
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-2014			
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of	Full-2014			

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**
discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness 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.				
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-2014			
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 state operated or state contracted psychiatric hospital.	Full-2014			
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.	Not Applicable - During interview, contractor stated members are able to access medications with no co-pays from the contractor. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should include the requirement for providers to assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program			

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**
	(KPAP) or other similar assistance programs in the BHS Provider Services Agreement and/or the BHS/Humana CareSource Provider Manual. **MCO Response:** Humana CareSource disagrees with this finding. Humana CareSource provides access to medications for no co-pay to all members. The concern with encouraging providers to use other programs is that the full medical history and prescription use of a member will not be known to Humana CareSource hindering care management programs. We feel that it is in the best interest of the member that the $0 co-pay benefit of their plan be utilized so that we are able to best serve our members. Final Review Determination: Not Applicable Humana-CareSource is correct. Access to medications with no co-pay fulfills this requirement, as additional assistance is not applicable.			
33.11 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	Full-2014			

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**
behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);				
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Full-2014			
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-2014			
D. Protect the confidentiality of Member information and records; and	Full-2014			
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2014			
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.				

Final Findings

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	4	0	0
Total Points	12	8	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		**2.5**		

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

Final Findings

Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Reports

Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements
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
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Humana-CareSource

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**
31.1 Pharmacy Requirements	**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently. **MCO Response:** Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.		**General Recommendation for Humana:** The Plan did not submit policies and procedures branded with the full MCO name Humana-CareSource.	
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. 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 including an accounts receivable process;	Full-2014			
B. Retrospective utilization review services;	Substantial - P/Ps addressing retrospective DUR were not	Full	New policy and procedure Rx -80, Drug Utilization Review, satisfies	

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**
	provided. MCO reports regarding drug utilization review (30, 40B, 41, 42A, 42B, 42C, 43, 44, 45A, 45B, 59) were provided. **Recommendation for Humana CareSource**: Develop a P/P to address retrospective DUR activities. **MCO Response:** Humana - CareSource agrees with the recommendation and has developed a new DUR Policy, inclusive Retrospective Drug Utilization Review, which goes to the P&P committee for approval in August 2014.		requirements. MCO reports regarding drug utilization review (30, 40B, 41, 42A, 42B, 42C, 43, 44, 45A, 45B, 59) were provided.	
C. Formulary and non-formulary services, including prior authorization services;	Full-2014		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports)	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere;	Full-2014			
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors; and	Full-2014			
F. Coverage for all drugs for which a federal rebate is available and has been provided by DMS.	New Requirement	Full	SOP Formulary Update Process (Medicaid) satisfies requirement.	

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**
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.	Full-2014			
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members via posting on the web and other relevant means of communication. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.	Full-2014			
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 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-2014			
31.3 Pharmacy Claims Administration				
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 prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.	Full-2014			

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 Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.	Full-2014			
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.	Full-2014			
31.4 Pharmacy Rebate Administration				
The Patient and Affordable Care Act (PPACA) signed into law in March 2010 require 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 including J-code conversions consistent with CMS requirements. The Department 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.	Non-Compliance - Evidence of this requirement was not provided either in policy and procedure or documentation. **Recommendation for Humana CareSource** Humana CareSource should develop a policy/procedure addressing the following: - assist the Department in resolving drug rebate disputes with the manufacturer - be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Substantial	The Drug Rebate Assistance policy and procedure (RX-81) and Pharmacy Rebate Administration – Non-Pharmacy settings (RX-82) policy and procedure satisfy the requirement. However, during the onsite interview, it was verified that Pharmacy Rebate Administration – Non-Pharmacy settings (RX-82) policy and procedure was not in effect in 2014. RX-82 policy and procedure was approved by the policy and procedure committee in January 2015. **Recommendation for Humana** The policy revisions should be approved and implemented.	Humana - CareSource agrees with the recommendation. Policy and Procedure was approved and implemented in January 2015

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**
	MCO Response: Humana – CareSource agrees with the recommendation and has developed a new Rebate Policy which goes to the P&P committee for approval in August 2014. The P&P is inclusive of : - How Humana - CareSource will assist the Department in resolving drug rebate disputes with the manufacture, - Also, Humana - CareSource will be responsible for administration of rebates on pharmaceuticals provided through non-pharmacy settings such as physician services.			
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization 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.	Substantial - Prospective DUR addressed in P/P: RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation. Policies and procedures regarding retrospective review were not provided. The following MCO reports include retrospective review documentation: 30, 40B,	Full	Prospective DUR satisfied in policy and procedures: RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation and RX-45, Clinical Utilization Management Pharmacy Edits. New policy and procedure RX-80, Drug Utilization Review, satisfies Retrospective DUR. RX-29, Quality Monitoring of Pharmacy Utilization Management	

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**
	41, 42A, 42B, 42C, 43, 44, 45A, 45B, 59. **Recommendation for Humana CareSource**: Develop a P/P to address retrospective DUR activities. **MCO Response:** Humana - CareSource agrees with the recommendation and has developed a new DUR Policy, inclusive Retrospective Drug Utilization Review, which goes to the P&P committee for approval in August 2014**.**		Activities addresses quality monitoring of UM activities. Quarterly Desk Audit Reports (KY Cov & Auth Summary Table) show pharmacy was the category with the highest number and highest percentage of denials, particularly Rx-Non BH-Brand for every quarter in 2014. KY Grievance Sys Summary Table, Report #29 shows Pharmacy as 1st or 2nd most frequent type of both member and provider appeals. The plan submitted the following MCO 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	

Final Findings
Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	3	1	0	0
Total Points	9	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		**2.75**		

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

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

Reports

Pharmacy reports